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Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

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MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 2) 2005

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BRISBANE

..DATE 10/10/2005

..DAY 21

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

THE COMMISSION RESUMED AT 10.00 A.M.

COMMISSIONER: Just before you start, Mr Andrews, there are a couple of preliminary matters. The first relates to an investigation which this Commission did in consequence of the evidence of Mr Kerslake, the Health Rights Commissioner. Counsel will recall that he appeared before the Commission on the 20th of September, and the Commission, and the parties before it, became aware then for the first time that the Health Rights Commission had obtained reports from a surgeon with respect to the work of Dr Patel, and on 26 September the Commission received from the Health Rights Commission 27 reports from Dr Allsop, a surgeon in Melbourne. These concern 27 of 60 patients in respect of which the Health Rights Commission had received complaints. Dr Allsop is yet to complete reports in respect of the others.

Of the 27 reports received, nine concern patients about whom evidence was given to this Commission by Dr Woodroffe, Dr de Lacy or Dr O'Loughlin. In respect of those patients, the reports reached generally similar results. Moreover, Dr Allsop's reports with respect to the other patients, neither add to nor subtract from findings and recommendations which I may make with respect to Dr Patel.

Dr Allsop's reports also discuss the work of three other doctors then employed at Bundaberg Base Hospital but none of them appear to raise a prima facie case against any of those doctors, either criminally or in respect of conduct the subject of action by the Medical Board.

Dr Allsop lives in Melbourne and is presently on holidays for three weeks in the Victorian countryside. In all of those circumstances, I propose to make his reports available to any party who wishes to see them. However, subject to any submission to the contrary, I do not propose to admit any of them into evidence or to require Dr Allsop to be called. Nor, in that event, would I make any findings or recommendations on the basis of any of those reports.

However, in the event of my concluding, on the basis of evidence before the Commission, that there is evidence sufficient to justify a referral of any conduct of Dr Patel to the Commission of the Police Service for investigation or prosecution, or conclude that there is sufficient evidence to justify the bringing of disciplinary, or other proceedings, or the taking of any other action in respect of Dr Patel, I will have in mind sending Dr Allsop's reports, together with those of Dr Woodroffe, de Lacy and O'Loughlin to the Commissioner of the Police Service or the appropriate disciplinary body, as the case may be.

If any party wishes to contend to the contrary of this course, they must make submissions in writing to the Commission setting out the basis of their contention on or before

14 October. There is just one other matter, and that is with respect to sitting times. We seem to be running out of time quickly and I had in mind that for this week, subject to any submissions counsel might make to the contrary, that we would adjourn for lunch for only an hour and resume at 2 o'clock in the afternoon and we would sit those same hours on Friday. Anyone have any objection to that? We will do that then.

Yes, Mr Andrews.

MR ANDREWS: With respect to the sittings on Friday, Commissioner, it may be that because Mr Leck has been given an appointment for Monday, it may be that there will be no witnesses to call on Friday. I simply foreshadow that, but I am sure as the week progresses-----

COMMISSIONER: You seem to be capable of finding them, don't you?

MR ANDREWS: Yes, although at this stage of the inquiry there are fewer to find.

COMMISSIONER: I hope so. Yes.

MR ANDREWS: Commissioner, before recalling Dr Naidoo, I wish to tender some documents. One is a certificate of registration special purpose for Dr Krishna for the period 18 July 2003 to 17 July 2004, and the other is a similar document but for Dr Sharma for the period 17 January 2005 to 16 January 2006. And the feature of each of those documents which causes me to tender them is that each is registered for a special purpose activity; that is to fill an Area of Need as a senior medical officer in orthopaedics at Fraser Coast Health District or any other public hospital authorised by the Medical Superintendent, and then there are other words-----

COMMISSIONER: Yes.

MR ANDREWS: -----but the significance, of course, Commissioner, is with respect to that matter that you raised last week, being the possibility that that form of words, senior medical officer in orthopaedics, may amount to registration as a specialist.

COMMISSIONER: Yes.

MR ANDREWS: I will tender those two documents as one exhibit, Commissioner.

COMMISSIONER: Well, they will together be Exhibit 438.

ADMITTED AND MARKED "EXHIBIT 438"

MR ANDREWS: Since the last adjournment, Commissioner, there

has been supplied by the solicitors for Dr Naidoo a statement of Andrew Christensen, a registered psychiatrist at the New Farm Clinic Consulting Suites, and the significance of it is that it reveals that in 2004-----

MR SEARLES: Excuse me, your Honour, may I interrupt and seek leave to appear this morning for Dr Naidoo until Mr Perry arrives? I understand that Mr Perry got Dr Naidoo - Mr Perry asked or elected not to have the evidence videod.

COMMISSIONER: It is-----

MR SEARLES: There seems to be-----

COMMISSIONER: I thought that was in his evidence. This isn't evidence of his. It might be evidence relating to him.

MR SEARLES: Very well, your Honour.

COMMISSIONER: I mean, you can make application to that effect if you like.

MR SEARLES: I beg your pardon?

COMMISSIONER: You can make an application to that effect if you like but I thought it was really just to protect him because he didn't want his photograph appearing, either.

MR SEARLES: That was certainly his intention in making that application, your Honour. This evidence seems to be connected with the evidence he has given, in the sense that it will be-----

COMMISSIONER: If it embarrasses him in some way-----

MR SEARLES: I would make that application, Mr Commissioner.

COMMISSIONER: Yes, all right. Well, I will make an order to that effect.

MR SEARLES: Thank you.

COMMISSIONER: Don't film that, please, thank you. Yes?

MR ANDREWS: Commissioner, it is exculpatory evidence that is about to be - I will be seeking to tender in a moment.

COMMISSIONER: Yes.

MR ANDREWS: It reveals that during 2004 Dr Naidoo was hospitalised at the New Farm Clinic for periods which in total seem to be about three weeks. That corresponds with the evidence that he had given in his earlier statement, save that the earlier statement tended to suggest that the three weeks were all in December of last year, whereas Dr Christensen's evidence shows that two of the weeks were in August and one was in the week from the 17th of December to the 23rd in 2004.

COMMISSIONER: Yes.

MR ANDREWS: I don't propose to call Dr Christensen. I tender that statement.

COMMISSIONER: Thank you. That will be Exhibit 439.

ADMITTED AND MARKED "EXHIBIT 439"

MR ANDREWS: Commissioner, you will recall that in Friday's evidence there was tendered evidence to suggest that Dr Naidoo's mobile telephone appeared to have placed calls from Kangaroo Point at various times during, specially, December of last year.

COMMISSIONER: Yes.

MR ANDREWS: Inquiries of Optus reveal that at this date it would be impossible to determine whether those calls were made from the New Farm Clinic or from Dr Naidoo's home for each source might conceivably, in December of last year, have resulted in notice which signified Kangaroo Point.

COMMISSIONER: So New Farm could have been shown on the forms as Kangaroo Point.

MR ANDREWS: That's so, Commissioner.

COMMISSIONER: Yes, all right.

MR ANDREWS: I recall Dr Naidoo.

MORGAN NEELAN NAIDOO, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Dr Naidoo, have you, during the weekend or this morning, prepared another statement dated the 10th of October 2005?-- Yes, I did, Mr Andrews.

Do you have an original of that with you?-- Yes, I do.

Are the facts recited in it true to the best of your knowledge?-- Yes.

I tender a copy of that statement, Commissioner.

COMMISSIONER: Yes. That will be Exhibit 440.

ADMITTED AND MARKED "EXHIBIT 440"

MR ANDREWS: Doctor, have you read the North Giblin Report?-- Yes, I have read it.

From within it there are some assertions I want to give you the opportunity to comment upon. It is suggested that the orthopaedic and fracture clinics at the Hervey Bay Hospital were not always supervised by a registered orthopaedic specialist. Well, that would be correct, wouldn't it, that they were not always supervised by you?-- That would be correct.

Or another specialist?-- That would be correct but could I qualify that, Mr Andrews?

Yes?-- The vast majority of clinics from my memory, except for one, was always associated with a consultant doing a clinic. So the fracture clinic would be held next door to the consultant's clinic.

That, of course, is unless you were on leave?-- Unless I was on leave, yeah.

It suggests that much of the work was done by the senior medical officers, Doctors Krishna and Sharma, at the orthopaedic and fracture clinics. That would be true, wouldn't it?-- That would be true with regard to the fracture clinics but not the orthopaedic clinics.

"Audit meetings", says the report, "are held only occasionally and these are poorly structured, purely documented and poorly attended." That would have been true in 2003 and 2004, would it not?-- No, I did supply to the district manager the recorded audits and discharge summaries for 2003/2004.

The fact that you were on leave so often meant that you were absent from the Fraser coast campuses, did it not?-- That's correct.

And that caused - that was an unacceptable situation for patient care at Fraser Coast, wasn't it?-- That's correct.

When you were not on leave, that is when you be at Fraser Coast, it would often be the case, wouldn't it, that you would be difficult to contact either because you were out of range or on the other campus-----?-- I would-----

-----or because you were unable to respond to your pager?-- The mobile phones didn't work in certain areas and if I was in transit between Maryborough and Hervey Bay, a certain segment of the area was not covered by mobile phones, and within the hospital there is drop-out areas with mobile phones. But I would emphasise that whenever I was on duty during the day, that I was either on one or the other of the campuses.

COMMISSIONER: Well, that's not correct, Dr Naidoo, there were some occasions when you were on duty when you were in

Brisbane?-- That was when I took leave, sir.

No, there was some occasions, as appeared from your evidence on Friday, when you were in Brisbane not on leave when you were supposed to be on duty?-- I can't recall exactly what those days were.

All right.

MR ANDREWS: The fact that you were at times the only specialist on duty and uncontactable, for one reason or another, meant that at those times it was unsafe, from the point of view of orthopaedic patients, didn't it?-- For the first five years when I was the only orthopaedic surgeon without SMOs, I didn't think there was any difficulty in me being contacted because I was always directly contactable, but when the SMOs came on Board, then they were allocated as the duty SMOs for the day, and the rosters will show that on each day there was an SMO allocated to cover each hospital, and the SMOs were the primary contact and I don't believe that the SMOs have indicated that they had difficulty contacting me.

Without the SMOs, your workload would have been intolerably high, wouldn't it?-- It was.

That meant that you were unlikely to be complaining about the SMOs, didn't it?-- Yes.

It is the case that your relationship with the SMOs broke down to the extent where you and the SMOs at times avoided speaking with one another?-- I don't think that ever occurred.

It is the case that by mid-2004, the SMOs were at times refusing to treat your patients? Do you recall that?-- I don't think that was the case, sir.

During your time, do you recall complaints that you were unavailable even during normal office hours, Monday to Friday?-- There were certainly complaints about that in the North Giblin Report, but I-----

Do you recall complaints from staff that you were unavailable?-- I could have been unavailable for various reasons.

COMMISSIONER: No, no, do you recall complaints by staff?-- No.

MR ANDREWS: Do you recall being questioned by Dr Hanelt as to whether you had been unavailable at times and Dr Hanelt asking you why?-- No, I can't.

Does that mean, doctor, that you remember it just didn't happen or does it mean you can't remember whether it happened or not? Do you understand the difference in the two questions?-- I can't remember whether it happened or not.

COMMISSIONER: It is not the sort of thing you would forget, though, is it, doctor?-- Well, if it did occur, it didn't occur frequently.

It is not the sort of thing you would forget, is it?-- If it was occurrent I wouldn't forget it.

Commissioner, I have no further questions.

COMMISSIONER: Thank you. Mr Searles, I will certainly leave you, or Mr Perry, if he arrives, to ask questions last.

MR SEARLES: Thank you, Commissioner.

MR MULLINS: I have no questions of this witness.

COMMISSIONER: Mr Allen, do you have questions?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Naidoo, John Allen for the Queensland Nurses' Union. At page 22 of the Giblin and North report, under the heading "Administration of the Orthopaedic Department", in the last paragraph of that section it reads: "Nursing staff also observed that there was little support from the orthopaedic department for nurses in emergency services and that the orthopaedic unit seemed completely disorganised and dysfunctional." If I could just ask you some questions about that. It is true that, of course, some orthopaedic cases come into the emergency department?-- All orthopaedic come into the emergency department.

That's their first port of call?-- That's their first port of call.

If someone fractures a finger or a leg, they are generally brought into the emergency department?-- That would be correct, yes.

And it is necessary for an orthopaedic surgeon, be it the consultant or an SMO, to at times go to the emergency department to review patients?-- Until the SMOs were employed, I was the consultant who would go down and look at those patients. After the employment of the SMOs, it was the duty SMO would go and assess the patient.

You no longer took any responsibility in attending the emergency department after the SMOs were employed?-- No, I didn't.

I see. But what if the SMO was busy in theatre?-- The SMO

who was on duty was left entirely free for the day. If he was tied up in theatre, then someone else will do that duty.

Who?-- Either the other SMO, myself, or if all of those were tied up in theatre, then we would send our resident medical officer to look at the patient and bring the X-rays or relevant material to theatre so that we could assess it.

So are you now saying that even after the employment of the SMOs, you would go to the emergency department if required to review patients?-- I certainly did.

You did?-- I did.

All right. Now, obviously if no-one is available to go to the emergency department to review an orthopaedic case, that would present difficulties?-- Yes, it would, yeah.

Because the patient would be sitting there untreated?-- Well, there are senior medical officers in the accident emergency department, as occurs in other hospitals, and they would initially assess the patients and then call the orthopaedic staff if further treatment was required. So it didn't mean that the patient wasn't seen.

No, but it was necessary for an orthopaedic review for the patient to be able to move from the emergency department to an appropriate ward?-- Then that decision could sometimes be made over the phone.

Over the phone?-- That's correct.

By an orthopaedic surgeon?-- That's correct.

Now, can I just take you to one case, which is perhaps an instance of what was being referred to in that part of the Giblin and North report? A patient P463. Now, can I suggest that P463 , a 93 year old lady, presented at the emergency department at about 4.15 a.m. on the 2nd of July 2004. The 2nd of July 2004 was a Friday and it was the last Friday immediately before you took a week's leave, which is described on the documents we have as being concessional leave?-- That's correct.

Okay. She was assessed in the emergency department that morning by a medical officer who recommended orthopaedic assessment?-- That's correct.

Now, the need for that assessment was fairly pressing, not only for her purposes but for the hospital's, because the situation at that time was that the hospital was full and that there was bed access block. Are you familiar with the term bed access block?-- Yes, I am.

There had been bed access block for about over 24 hours. Now, that means, does it not, that all the beds in the emergency department are full and that if patients can't move on from there, then other admissions can't be taken by the hospital?--

That's correct, yeah.

I suggest that staff in the emergency department raised concerns with their nurse unit manager that morning at about 9.30 a.m. regarding the fact that there had been no orthopaedic review of this lady, notwithstanding that she had been in the emergency department for over five hours?-- I don't know the exact reason for that but I can be sure there would have been a duty SMO allocated for that day.

A duty SMO. Could that, for instance, be Dr Krishna?-- Dr Krishna or Dr Sharma.

See, I suggest that Dr Krishna had been contacted and he'd sent a message back to the emergency department from the operating theatre that it would be - wouldn't be until approximately 1.15 p.m. that he would be available to review patients?-- I can't recall exactly what Dr Krishna was doing that day, but I will also state that P463 had a problem of recurrent back and neck pain since 1988 and she attended Maryborough Hospital from 1988 to about the 2nd of July, and the 2nd of July was her first admission, and most of her treatment was at an outpatient level involving medication and physiotherapy, and the period that you referred to where she was admitted was from the 2nd of July to about the 5th of July, if my memory is correct - I don't have the notes with me-----

No, you're quite correct?-- Yeah, and she had no neurological signs and she was treated with analgesia and I didn't see any initial clinical reports from Dr Krishna but the last entry from Dr Krishna which clearly states that the arm pain and the back pain had settled. As far as the investigations were concerned, she had all the investigations she required to have and my assessment of her diagnosis was that she had osteoporosis, that is, softening of the bone involving the entire spine with degenerative changes most noticeable in the cervical spine.

If we go back to the 2nd of July, I'm asking you about the events on that day. I suggest that by this stage, there was another patient in emergency department awaiting review, Dr Krishna had indicated he was in theatre and couldn't come, Dr Sharma was conducting the specialist clinic?-- No, it wasn't a specialist clinic, he was conducting a fracture clinic, yes.

Right. And you were in a consultation room, not seeing patients?-- I was in clinic doing a hand clinic which is my-----

No, you weren't, doctor, you were sitting in a room without any other person when the nurse unit manager of the emergency department, Ms Champion, approached you and asked you if you could see the emergency department patients because the emergency department was full and there was going to be a four hour delay in getting an orthopaedic consultation from Dr Krishna?-- Well, I'm scheduled to do a hand clinic on the Friday morning at the time that she questioned.

COMMISSIONER: That doesn't seem to answer the question, doctor. Was her statement of recollection of facts correct, that you were sitting in a room in outpatients and she came and asked you that?-- I'm not certain of that.

All right.

MR ALLEN: I suggest that you appeared to be doing personal paperwork, you had what appeared to be personal bills in front of you?-- Well, it could be bills related to the hospital.

Or it could be personal bills?-- I don't take personal bills to the hospital.

I see, you weren't doing your paperwork ready for your holiday the next week?-- I can't recall.

You simply told her, "Admit the patients and they can be reviewed later."?-- Well, sir, there's an SMO on duty-----

COMMISSIONER: No, no, did you tell her that or not?-- I can't recall telling her that.

MR ALLEN: She told you that there was no beds in the hospital and that they should be reviewed in the emergency department rather than being simply admitted to the hospital which might be inappropriate?-- Well, in my opinion-----

COMMISSIONER: No, did she tell you that or not?-- No, I can't recall her telling me that.

Please listen to the question, doctor, and answer the question.

MR ALLEN: I suggest you still refused to see the patients in the emergency department?-- I can't recall. If it was an emergency I would have definitely seen the patient.

But if it was simply this 92 year old lady who had a long history of back pain, you wouldn't have bothered; is that what you're saying?-- What I'm saying is that there's a Senior Medical Officer on duty who is fully capable of determining whether a patient needed admission or needed could be discharged to the care of a general practitioner or would require an outpatient appointment and if the patient required to be admitted and there was no beds available, then arrangements needed to be made by the Accident & Emergency Department rather than by myself, yes.

But Ms Champion had told you that both of the SMOs were otherwise engaged and could not see this patient?-- I'm not talking about the orthopaedic SMOs, I'm talking about the SMOs in Accident & Emergency.

Weren't they entitled to seek an orthopaedic review according to the normal protocol?-- Well, I think an SMO is capable of determining whether a patient needs to be admitted and if there was no beds available, that's beyond my control.

Well no, why didn't you get up and go and see the patients yourself in the emergency department?-- I can't recall the exact details of that occasion.

Did the district manager speak to you about this incident and your refusal to see patients?-- No, he didn't.

So you're quite certain that the district manager didn't talk to you about that incident?-- No.

Okay. I'll just ask you to have a look at this on the screen please? It's a document which is TMH 22 exhibited to Mr Hanelt's statement, and you'll see that it's an e-mail from Theresa Winstone to Mr Hanelt, subject "The Orthopaedic Team, 18 June 2004". Now, could you just have a look at the first two paragraphs, read them to yourself? Now, have you seen that document before?-- No, I haven't seen it before.

All right. Was the contents of that second paragraph raised as a topic of discussion with you by Mr Hanelt at any time?-- No, it wasn't.

So he never approached you and spoke about the incident described?-- No. Can I qualify what I'm what you asked me?

Yes?-- The SMOs are rostered to do a ward round each morning

between eight and nine and they will see those see every patient that's come in, including post operative patients, and I do an official ward round which is a teaching ward round on Tuesdays and Thursdays following their ward round and on other days I would only see patients in the wards if I was specifically asked to do so by the SMOs. The problems at that time that the SMOs had were that the ward was left without an RMO, that's a resident medical officer, for an extended period to do the routine ward work that involved clerking patients, writing up the patients medications, doing the discharge summaries and attending to relatively minor problems that the resident medical officers do, and that was a frequent problem in orthopaedics, that there won't be a resident medical officer.

COMMISSIONER: Doctor, you were in the hospital that Thursday?-- Yes, I was, yes.

Did you receive the messages that were left for you?-- On Thursdays I do a clinic but I can't recall receiving any of those messages.

All right.

MR ALLEN: I'll ask you to have a look at this document?-- I will say my Thursday clinic is a busy clinic, I see about 18 patients.

COMMISSIONER: Mmm.

MR ALLEN: Now, this is a discharge summary in relation to the patient who's discussed, you're the consultant, a P450?-- That's correct, yes.

And she was admitted on the 15th of June 2004?-- That's correct.

And if we scroll down, you can see the procedure that you undertook?-- That's right, yes.

On the 15th of June 2004?-- That's correct.

There were no post-op complications?-- Her post-operative care was uneventful, yes.

Now, this discharge summary's dated - well, it notes that she is discharged on 17th of June. If we just go down a bit, who signed the discharge summary?-- It would be one of the resident medical officers placing the medical resident medical officer who dictated the summary.

I see, so another RMO has signed for Paul Chapman, RMO, for you?-- No, I don't sign the discharge summaries.

And it's been dictated on the 25th of June 2004?-- According to that document it would be correct, yes.

After your follow-up clinic on the 24th of June 2004?-- Yes.

I'll tender that document, the discharge summary.

COMMISSIONER: Yes. That will be Exhibit 441.

ADMITTED AND MARKED "EXHIBIT 441"

WITNESS: Could I also elaborate on why there was the delay in the discharge summaries?

MR ALLEN: Yes please?-- We have two types of discharge summaries: one, a handwritten discharge summary which contains very little detail, it's required for the general practitioner to manage the patient, and then we have formal discharge summary of the type that you've just seen, and if there's no resident medical officer available, then there's a significant delay in the summaries being discharged.

I see?-- Or if there's problems on the administrative side with typing, it could be delayed.

Well, could we look at this document? Is this the handwritten discharge summary you referred to?-- That's right, that's correct.

Addressed to the GP?-- That's right.

All right. If we go down the bottom of that, that's dated the 17th of June 2004 and who's the medical officer who has prepared it?-- That looks like Dr Krishna's signature to me and it's unusual for the senior medical officer to do a discharge summary and that would indicate that there was no RMO present at that time.

I'll tender that discharge summary.

COMMISSIONER: That will be Exhibit 442.

ADMITTED AND MARKED "EXHIBIT 442"

MR ALLEN: Now, according to that e-mail you were asked to look at, and according to documents we've seen, this patient was admitted on the 15th of June which was a Tuesday for an operation that day?-- That's correct, yes.

There were no post-op complications. Would it be the usual course that such a patient would be, in the absence of any complications, stay in the hospital overnight following the operation and be discharged the next day?-- Well, I said the operation was uneventful and because of the nature of the

operation and the pain that will be associated with it, she needed to stay in overnight.

Yes, there'd be an overnight stay the same night of the operation?-- That's correct.

Okay, so it would have been anticipated by the patient and by the hospital that she would have stayed in on the Tuesday night?-- That's correct.

Following the operation on that day?-- That's correct.

And that she would be reviewed by the appropriate orthopaedic personnel the following day?-- That's correct.

In the morning?-- That's correct.

During a ward round; is that correct?-- That's correct, yes.

Well, according to the e-mail, the - neither Dr Krishna nor Dr Sharma saw the patient the following day after the operation and they said the reason was that Dr Naidoo wanted to see her before she went home?-- The SMO that's allocated to working with me should see all patients that are under my care.

But would you need to see the patient who had undergone an arthroplasty by yourself before that patient was discharged?-- Not unless there were any problems, no.

No?-- Not unless there were any problems.

Not unless there were any problems? There's been certain limitations placed upon the SMOs practice in regards to arthroplasties; is that correct?-- That's correct, yes.

You were the person who really was in charge of such cases?-- I was the person in charge of doing the operations.

Wouldn't it be conceivable that both Dr Krishna and Sharma would regard it necessary for you to review arthroplasty patients before they were discharged?-- I would only review the arthroplasty patients if they were a long stay patient like a knee arthroplasty or a hip arthroplasty on my usual ward rounds, but if the patient had no problems and it wasn't indicated to me, then they were entitled to discharge the patient and there's a protocol for follow-up and from the documents she presented, it seems to me that that protocol was followed.

Could you have a look at this page of the patient's progress notes? We see at the top of the page that on 15th of June 2004 she has been admitted to the ward following the operation?-- That's correct, yes.

Then the following day there's an additional note made at 3 o'clock, "Not seen by Dr Krishna this morning, awaiting review by Dr Morgan."; Dr Morgan refers to yourself?-- That's correct, yes.

So the indication - information recorded by the nursing staff is that the patient hasn't been reviewed by Dr Krishna because she's supposed to be reviewed by yourself?-- That's correct.

I suggest to you that as described in the e-mail, despite messages being left for yourself, you did not see the patient that day?-- Well, to the best of my knowledge I did not get a message from Dr Krishna.

Or from nursing staff?-- Or from nursing staff.

So you're saying you never got a message from Dr Krishna or nursing staff that the patient was awaiting review by yourself so she could be discharged?-- That's correct, yes, and if it was on a Wednesday, then I would have been at Maryborough.

The e-mail suggests that because of your failure to review her, she had to stay another night in hospital; what do you say about that?-- Well, if I wasn't aware that she was still in hospital, I couldn't do anything about it.

And then that next day, the 17th, it appears that the information given to staff was that you were off sick, so you couldn't see her then either?-- On the 17th of June?

Yes?-- If that's what the document indicates, then that will be correct.

Well no, the leave documents don't indicate that you had sick leave at all that day?-- On a Wednesday I'm in Maryborough, on a Thursday I'm in Hervey Bay doing a clinic, a very large clinic in the morning.

Well, you weren't that day, I suggest, you didn't attend the hospital?-- I have no recollection of that.

And so eventually she was seen on the ward round of the 17th of June by what, an SMO by the look of it, and she was discharged to be seen at your clinic later?-- Well, that looks like Dr Krishna's signature, yes.

Now, it not only causes distress to a patient to be unnecessarily kept in hospital an additional day, but it causes difficulties for the running of the hospital, doesn't it?-- It does, yes.

When beds are scarce?-- It does.

It's a drain on resources which is unnecessary?-- It does.

It's completely unacceptable, I'd suggest, that this patient had to stay in an additional night because Dr Krishna insisted you see her and you never did?-- Well, I was sure he didn't make contact with me regarding me seeing the patient and discharging the patient. As is in practice in most hospitals, either Registrars or senior medical staff working with a consultant will receive instructions from the consultant that

a patient can be discharged on a certain day unless there's problems.

Commissioner, can I tender that page of the progress notes?

COMMISSIONER: Yes. That will be Exhibit 443.

ADMITTED AND MARKED "EXHIBIT 443"

MR ALLEN: If I could just ask Dr Naidoo to have a look at this document on the visualiser? This is another document which is exhibited to Mr Hanelt's statement - or Dr Hanelt's statement, TMH 21. Just read that through to yourself please?-- Yes.

Now, you're aware that Miss Erwin was the nurse unit manager of the operating theatre?-- That's correct, yes.

It's hardly a flattering picture being painted by her of yourself and the SMOs, is it?-- Well, it's just a matter of her opinion, I don't think that was really the case.

Did Dr Hanelt raise with you the contents of that e-mail he had received?-- No.

Have you ever seen that document?-- No, I haven't seen that document.

And you're quite certain that he didn't raise and discuss with you the issues and concerns discussed in that document?-- I certainly don't recollect him doing that.

Yes, thank you, I'll ask for that to be returned. Those are my questions, Commissioner.

COMMISSIONER: Thank you. Ms McMillan?

MS McMILLAN: Yes, thank you Commissioner.

CROSS-EXAMINATION:

MS McMILLAN: Dr Naidoo, my name's McMillan, I represent the Medical Board. Doctor, can I just ask some questions firstly in relation to Dr Christiansen's statement? I understand from your first statement that you're working - at the current time you're on stress leave; is that correct?-- That's correct.

How long do you understand that stress leave is to continue for?-- Well, I have been on stress leave on the 15th of August.

Mmm?-- I returned to hospital - I returned to the hospital from my recreation leave a week earlier when the issues regarding Hervey Bay were raised.

Mmm?-- And I was informed that I could do administrative work and if you look at my duty roster, the administrative work is restricted to about two or three out of 10 sessions.

Mmm-hmm?-- And being - because of the size of the department and the number of consultants, there's not a great deal of administration, apart from the audits, rosters, memos, so I was left with a large part of the week sitting on a chair quite humiliated when contingency arrangements were made for orthopaedic surgeons to be brought from Brisbane at great cost to do relatively simple procedures.

Sorry, Dr Naidoo, if I can just short-circuit your answer; are you still on stress leave at the moment?-- Yes, I am.

Right.

COMMISSIONER: Ms McMillan, can I interrupt you to ask you what is the question directed to? I would be very concerned if the Medical Board was using this Inquiry as a searching ground for evidence which might be used by the board?

MS McMILLAN: Well, I just wanted to clarify the current status.

COMMISSIONER: Well, I can't see that relevance of it.

MS McMILLAN: Very well then, I won't pursue that, thank you. I take your point, Commissioner.

Doctor, I want to ask you some questions in relation to a couple of patient cases, and I understand you've had the opportunity to look at a couple of patient records; correct?-- That's correct, yes.

All right. Now, the first one I want to ask you is in relation to a P430 ; do you recall her case?-- I do.

She was an elderly lady, is this correct, that was admitted to the hospital late in the evening on the 25th of July in 2000?-- That's correct, yes.

She had a fractured left arm and she also suffered dementia; you say this at 8.6 of your statement; correct?-- That's correct.

She also had some cardiac problems, didn't she?-- That's correct.

Right. Now, you say you first saw the lady on the 27th of July; correct?-- That's correct, yes.

And you placed her arm in a plaster splint?-- That's correct.

All right. You go on in your statement to say why that's an appropriate procedure to undertake?-- That's right.

And as I understand it, is this correct: firstly, you say although it wasn't ideal, you didn't do the fixation with the splint and screws because of the osteoporosis and also because of the dementia situation; correct?-- That's correct. And can I qualify that?

Yes?-- The patient was an elderly patient with severe dementia, was physically out of control and the nursing staff notes indicate that.

Yes?-- She was obese, she had cardiac problems and I think from memory was either third degree or second degree cardiac block and has been highlighted that she was an orthopaedic admission but she was admitted to the medical ward.

Yes, you point that out?-- And-----

COMMISSIONER: This has already been pointed out in your statement, Dr Naidoo, I don't need think you need to repeat anything that's already in there?-- Right.

MS McMILLAN: Now, the first reason, as I indicated, the first reason was the osteoporosis; secondly, because she had the dementia; correct?-- That's correct.

Then you go on to say the ideal procedure would have been an intramedullary nail with the fixation but you go on to say the difficulty about the risk of mortality and you would have had to borrow the equipment, effectively?-- That's correct, yes.

So, was it on balance you thought the best thing to do was to put her in plaster; is that correct?-- That's correct.

All right. You then say at 8.13, "Because it became an open wound, Dr Mullen debrided the wound, put an external fixator with screws."; do you recall putting that in your statement?-- That's correct, yes.

Right. Now, would you say that that was a correct approach once it became an open wound?-- That's correct.

Right. So would you not have put it in plaster if it was already an open wound by the 27th of July?-- Initially the wound was a small wound and we considered the risks to the patient because the anaesthetists do repeatedly say the patient was unfit for surgery.

COMMISSIONER: So it was an open wound right from the start?-- It wasn't an open wound from the start.

I thought you said it was a small wound but an open wound?-- At the time when it was described as a wound, so the initial fracture was a closed fracture.

Well, does "a wound" mean an open wound?-- Sir, the initial fracture was-----

Doesn't "a wound" mean an open wound?-- That's correct.

Thank you.

MS McMILLAN: Right. Because, doctor, if I could just refresh your memory, there is just one line so I will read it to you, nurse's note of the 27th of July, and this is prior to theatre, "1340 hours: broken area of skin noted over", and it's - looks like "fracture site", the cross. So that denotes fracture, doesn't it?-- That's correct.

So it was broken, wasn't it, the area of skin prior to her going into theatre, wasn't it?-- Prior to me taking her to theatre?

Yes?-- No.

HIS HONOUR: I thought you said it was. I thought you said it was small but an open wound?-- No. At the time I took her to theatre, it was a closed fracture.

I see.

MS McMILLAN: Do you want to have a look at this nursing note to refresh your memory for a moment?-- I'm pretty clear about it.

All right?-- It was a closed fracture at the time.

COMMISSIONER: So your evidence is inconsistent with the nursing note; is that what you say? Your recollection is different from the nursing recollection apparently?-- That's correct.

All right.

MS McMILLAN: Right. And were you aware that the patient had already removed one lot of plaster from her arm prior to you operating on her on the 27th, according to the nursing note?-- That's correct.

Right. So, given - you say you disagree it was an open wound, but in relation to her having already removed one lot of plaster from her arm, do you say that it was an appropriate course to effectively replace it with another plaster cast, which you did on the 27th of July?-- The first plaster was put on by a junior doctor in the hospital.

Was that in the Accident and Emergency-----?-- Accident and Emergency Department, without any attention to alignment or reduction of the fracture.

Yes?-- Then as soon as the anaesthetists were happy about doing something with the patient, we elected to reduce by a fracture, and if you note that we did it under sedation rather

than under general anaesthetic-----

Yes. I think you say that in your statement. Doctor, I'm not for a moment asking you about internally what you did in terms of reducing, I'm asking you about the method by putting plaster on again when you are aware she had already removed one plaster?-- Well, I put the - I put an appropriate plaster-----

Yes, but I am asking you about the appropriateness of doing it to an elderly lady who's suffering from dementia, who as you say you had difficulty in controlling, and that was a difficulty you say with the procedure adopted by Dr Mullen; correct?-- That's correct.

And I'm asking you about the appropriateness of undertaking what you did, given the fact that she'd already removed one lot of plaster, you see?-- That was based on the - my opinion on the outcome of the other two alternatives. One was the plating and the other was the external fixateur.

Now, in relation to the intramedullary nail, you say that that would have been a delay. Did you firstly ask the anaesthetists whether it would have been possible to have that procedure conducted upon P430?-- There were reluctant to do so because she was - there's notes - entries in her notes she was medically unfit.

Can I stop you there? Did you make inquiries as whether that was possible to do so?-- In those sort of cases-----

COMMISSIONER: No, no.

MS McMILLAN: No.

COMMISSIONER: Please listen to the question, doctor. It would be very helpful if you would listen to the question being asked and answer it?-- Sorry.

You were asked whether you asked a certain question?-- I did.

MS McMILLAN: You did. Who did you ask?-- I can't recall the junior anaesthetist's-----

But you definitely inquired of junior anaesthetist whether that was possible-----?-- I would-----

-----to conduct that sort of procedure?-- I will.

You did?-- Yes, I did.

You made that call. Now, it's correct, isn't it, that you reviewed her on the 28th of July; is that right?-- That's correct.

And did you review her again in person whilst she was an in-patient of the hospital?-- Not until after Dr Mullen had done his surgery, so as soon as I was back at the hospital.

Right. Is this correct, that you did not see her again before you went on leave on the 31st of July?-- I don't recall seeing her.

Well, if I put it to you this way, you say you went on leave on the 31st of July. You accept that?-- That is correct, yes.

Right. And the notes - the notes indicate that there was contact made with you. For instance, the 29th of July, "Dr Naidoo contacted. Advised patient medically very unfit. Patient-----", et cetera. You gave some advice. Does that ring a bell?-- That's correct, yes.

And the 30th of July, "Patient still same, deteriorating, confused, back slab on the right arm. Dr Naidoo informed last night and she's medically too unwell, then discussed with James." A medical PHO?-- That's correct.

Principal House Officer. So contact was made with you, I gather, by phone, was it?-- That would be correct.

Right. Now, it's correct, is it, that the picture of this lady was that she certainly wasn't improving prior to you going on your leave on the 31st of July. Would that be a fair assessment?-- That would be correct, yes.

Right. Now, you're aware, aren't you, that Dr Mullen has given evidence about this patient's case, has he not?-- That's correct.

Have you read the transcript in relation to his evidence?-- Yes, I did.

All right. Now, he said - and it's at page 5453, Mr Commissioner - "That most importantly with these sorts of situations" - that is that you be contactable, had to be more than contactable - "with these sorts of situations is proximity, and that is none of us expect that we will be present 24 hours a day all the time. It's not possible. But if there is a problem which needs dealing with, then the proximity had to be such that you can attend in a fairly prompt period of time to deal with the problem." Now, would you accept that that's a fair comment?-- That would be a fair comment, but I don't think I was on call that weekend, and the Director of Surgery, Dr Griffiths, who was on the orthopaedic roster was on call.

That was at a time, wasn't it, that Drs Krishna and Sharma weren't at the hospital, were they? This is 2000?-- Yes, that's correct, yes.

And so if there was a roster, you had somebody who was not experienced in orthopaedics at all on call if you weren't there?-- Yes.

Right. So, given, you'd accept, that this was a situation you

have already agreed was deteriorating, despite the fact that you weren't, as you say, on call, you didn't consider you should go in and see this lady?-- If I wasn't on call, I would have been in Hervey Bay.

All right. And you are sure you weren't on call that weekend?-- If - to the best of my recollection.

Now, you are aware, aren't you, that Dr Kate, as she's known - do you know that doctor, she was an RMO?-- Dr?

Kate?-- I can't recall exactly who she is.

According to Dr Mullen - prepared a summary of the admissions and what was occurring with the patient. Can I have just that shown up on the screen, please. That's the summary that appears on the chart. Have you seen that before, Dr Naidoo?-- Yes, I have.

All right. And you will see that on the 26th, as I have put to you, she was unfit to operate. The back slab was reapplied. That's the plaster, isn't it?-- That's correct, yes.

She'd removed it overnight on the 27th prior to her being booked for the surgery; correct?-- That's correct, yeah.

It's noted there, "Proximal fragment punctured skin 11 a.m." Do you see there?-- That's correct.

All right. And you will see by the 29th of July number 5, "Bandaged soaked with fluid. Bandage removed. Bones seen medially." So you were advised according to these notes on the 29th of July that the bone was able to be seen, "back slab left unsightly", and were rebandaged. You were advised by the 29th of July that the bone was able to be seen medially?-- I'm not certain of that.

The 31st was the day you went on leave. Were you contacted at all, as you recall?-- No, I can't recall being contacted.

Commissioner, I tender that page.

COMMISSIONER: Yes. That will be Exhibit-----

MS McMILLAN: Perhaps at a convenient time could that just be removed? That's a copy. That's actually annexed to Dr Mullen's statement, but it's part of a very large annexure.

COMMISSIONER: If it's part of Dr Mullen's statement it would already be an exhibit.

MS McMILLAN: Yes, it would be. Perhaps if I just flag it as-----

COMMISSIONER: Yes, I think that would be sufficient. I don't want to duplicate exhibits if we don't have to.

MS McMILLAN: No. No.

COMMISSIONER: All right.

MS McMILLAN: Thank you. All right. Now, Dr Mullen has said that in his evidence, as you have read, that he's not seen this sort of fracture effectively end up with an amputation. You have read that in his evidence. Would you agree with that?-- I would agree with that.

You, in fact, performed the amputation on P430, didn't you, in August-----?-- I did.

-----of that year. All right. He says at page 5453 as well that he believes that the delay that there was in relation to her care would have led to the outcome of amputation because of the delay in care at that time. Do you accept that is valid criticism, if you like, of her care at that time?-- No, I don't. Because within a few days of the external fixture being put on, which was done appropriately and certainly it was correct procedure to do at that time, the patient had pulled the external fixture apart and further fragmented the fracture.

So, in essence, do you say that this was a difficult situation then?-- It was a very difficult situation.

With the particular patient and the difficulties that she had, the comorbidity, if you like, the dementia and also the cardiac problems?-- That's correct.

Wouldn't that then, if you like, have redoubled efforts to make sure that she was closely observed by someone with real experience in orthopaedics?-- That's correct.

Did you make any arrangements for her to be looked after - you went on leave on the 31st of July?-- Not directly, no.

Well, if it was not directly, how would you do it indirectly?-- Indirectly, the surgical PHO, if I - this is from recollection - who was on call for the weekend, looks at all patients, whether they are general surgery or orthopaedics, and at that stage we were being assisted for the on call rosters by the two surgical consultants, and of the two Dr Griffiths had some orthopaedic practice, and before I came into the district he did several orthopaedic procedures.

But I take it that you were aware that he had this background, but I take it that there was no particular handover, if you like, that you did with him?-- Dr Griffiths would do a ward round with the surgical PHO on a Saturday and a Sunday and there's a note in the - in the file that Dr Griffiths has - had seen the patient.

Yes. But I take it that you certainly hadn't done any ward rounds with Dr Griffiths in terms of a handover, if you like, so that, "This lady has more difficulties, I'm going on leave, I want you to keep a close eye on her."?-- No, I didn't.

Was there never any system that, for instance, somebody like this where there's perhaps a fairly dicey situation, that you might have made some arrangement with Dr Mullen when you are going to be absent on leave?-- Well, as far as I'm aware when Dr Mullen was called to assist when I was on leave, he was not available.

So was that just from your general knowledge that he wasn't-----?-- That's correct.

-----available. All right.

COMMISSIONER: You weren't getting on well with Dr Mullen?-- Yes.

MS McMILLAN: I want to ask you about patient P446 . You have again had some opportunity to look at his records, haven't you?-- That's correct.

All right. He was a 15 year old lad, wasn't he?-- That's correct.

Known as P446, I think, in the coding. You did the operation upon him. In fact, both operations, did you not?-- That's correct, yes.

All right. Now, you recall those operations, what you did?-- I do.

Now, it's correct to say, isn't it - and if I could have the first flagged document shown there, that's number 1. If you could go to the next document in that, please. Yes, thank you. That was the first on the right, wasn't it, on the 24th of May 2004?-- That's correct, yes.

All right. That was the open reduction and the internal fixation of the fractured tibial plateau, correct?-- That's correct.

Right. And that was - would you regard that as a fairly difficult operation?-- It's an operation that I had done plenty - several times, yes.

COMMISSIONER: Is it a difficult operation or an easy one?-- It is a difficult one.

MS McMILLAN: And is it correct that this break actually extended into the actual knee joint?-- That's correct, yes.

Now, would you say that - do you recollect the actual operation? Was it reduced back into the actual correct position?-- As best as I could see at the time of the operation, it did.

All right. Now, you have read - have you read Dr Crawford's evidence?-- I did, yes.

All right. And you will see that he's critical of both, in fact, operations performed upon P446, isn't he?-- That's correct.

All right. And just while we're at it, the second operation is done, is performed on the 2nd of June, isn't it?-- That's correct.

So within a week, approximately a week. All right. Now, his evidence - at transcript page 6309, Mr Commissioner - his criticism was that it needed to be reduced back into the correct place. Well, you say that you did so?-- Yes, I did.

And that the screws were too short that were utilised on that first operation. What do you say about that?-- I don't think the screws were too short because we used a special type of plate for that fracture.

All right. And he added, "Both too short. There was a bit of bone from the joint which hadn't been put back into place." Do you accept that? He said he could observe that from the X-rays?-- From the initial X-rays or the second X-rays?

As I understand it the X-rays between the first and second operation?-- That's correct, and I recognised that as well.

All right. Because it's correct to say that when the - this is on the Discharge Summary, is it not? And that's document number 3 right at the back. If you you could go to that, please. Just scroll down, please. He was taken - after post-op X-rays were reviewed it was decided to return to theatre. That's correct, wasn't it? After they reviewed, he was returned to theatre?-- That's correct.

Was the basis, was it not, from what I put to you, as Dr Crawford described?-- That's correct.

Okay. And then the second operation was performed; correct?-- That's correct.

Now, he says about the second operation - transcript page 6310 - that the second operation was to try to pull the bone back together; is that correct?-- That's right, yes.

But I suspect it wasn't recognised that the bones were in the wrong place and you know couldn't be pulled back together with just the screws. Do you accept that?-- No, I don't, because we used a compression clamp to get the bones together and then insert the screws percutaneously. The reason for that was I thought a more extensive procedure would expose the patient to infection.

Well, on the next page he was asked by Mr Andrews, "And is that why you say the second operation really ought to have opened up the wound again, put the bone back together?" "Yes, moved bits of bone back into place." You say you wouldn't have done that because of the risk of infection. Is that what you are saying?-- That's correct, yes. Because can I also

make - qualify the nature of his injury?

I'm sorry?-- Can I qualify the nature of his injury?

Yes?-- And I think Dr Crawford's made the statement as well, it was a pretty nasty fracture with significant depression of the tibial plateaus.

Yes?-- And the knee was quite unstable. So, we gave great attention to elevating the fracture to the joint - correct joint level, inserting bone grafts, and reattaching the cruciate ligament, and as far as I could see through - at the time of the operation, it looked adequately reduced.

Now, it's correct to say that the lad seems to have healed well, his injury; correct?-- Yes.

Are you aware of that?-- In my absence he was followed up by Dr Kwon.

Could I see the top page of those documents? That's a letter of Dr Kwon's. All right. He said, "Clinically the wounds have healed well without any problem." Do you see that there, that-----?-- That's correct.

-----letter from January this year. He says, "I have informed both Dylan and his mother he will likely have early onset of secondary osteoarthritis in his later years." He's given them some advice following that. Do you accept that he's at risk of early onset?-- Yes, I do.

And I understand that it's possible no matter what sort of - that after that sort of injury one might face the onset of the osteoarthritis in that joint; is that correct?-- That's correct, yes.

Dr Crawford, at 6311, was asked by Mr Andrews again, "Does it seem reasonable to conclude that the prospects of his suffering arthritis later are increased because of the way these procedures were performed?" He answered, "Yes." Would you accept that what he states there is an opinion?-- No, I don't.

Why not, doctor?-- I think the chances of you determining osteoarthritis is determined at the time of injury and the amount of damage you do to the articular surface, so you can accurately reduce the bones but you can't correct the articular surface.

Doctor, whilst the patient was an in-patient of the hospital, did you review him at all in ward rounds?-- To the best of my knowledge, I would have.

Are you sure about that?-- To the best of my recollection.

Would you regard that as a normal part of your practice, if you'd operated on patients that you would routinely review them in ward rounds?-- I would routinely see them.

I indicate to you that I can't observe in the chart where you have reviewed him again after the second operation. What would you say to that?-- I may or may have at the time of review.

You may not have at the time of review. Would there be a reason why you wouldn't have reviewed him, given he was your surgical patient?-- There wouldn't be a reason.

Sorry?-- No.

No. Yes, thank you, Mr Commissioner.

COMMISSIONER: Thank you. I will take a short adjournment before you cross-examine

THE COMMISSION ADJOURNED AT 11.22 A.M.

THE COMMISSION RESUMED AT 11.41 A.M.

MORGAN NEELAN NAIDOO, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr McDougall, when you are ready.

MR McDOUGALL: Thank you. Doctor, you say in your statement at paragraph 1.2 that you have been employed by Queensland Health as the Director of Orthopaedics at Hervey Bay Hospital since 1997. That's not in fact correct, is it? You were only employed as a Director of Orthopaedics since 2002?-- That's correct.

Prior to that you were an employed staff specialist?-- That's correct.

Very well. It is the case, isn't it, Dr Naidoo, that the nature of the orthopaedics department at Hervey Bay Hospital has changed since the hospital opened in 1997?-- Yeah, I think it has, yeah.

It has become busier?-- It has.

It was in about 1998, was it not, that the hospital was - if I can use this word not in an official sort of way - sort of recategorised as a 24 hour acute care hospital?-- That's correct.

And that from thereon orthopaedic trauma had to be treated - where possible was treated at the hospital?-- That's correct.

And in other areas of specialty, for example obstetrics and so on, 24 hour care was offered in those, in, for example, paediatrics and obstetrics over time as well?-- That's correct, yes.

And it has been the case, hasn't it, that since about 1998 attempts have been made to recruit specialists in all disciplines that the hospital needed, including orthopaedics, with some difficulty?-- That's correct.

And from - well, at least since 1998 that's been the ongoing concern of the authorities who run the hospital?-- That's correct.

It has been the subject of discussion at meetings at least twice monthly with the specialist medical staff?-- That's right.

At the Surgical Management Advisory Group meeting once a month?-- That's correct.

And the senior medical staff meeting once a month?-- That's correct.

You attended those meetings, did you not?-- I attended as many as I could.

And that was the ongoing subject of discussion at those meetings, the difficulty in recruiting specialist medical staff at the hospital?-- That's correct.

Including orthopaedic staff?-- Certainly including orthopaedic, yeah.

A question was put to you by my learned friend counsel assisting this Commission on Friday about the meeting you had with Dr Hanelt and Dr Mullen on the 16th of January 2004. Do you recall that meeting?-- I do.

At that meeting there was a document - a memorandum produced that all of you signed that you have seen in evidence. It was shown to you during your evidence-in-chief. Do you recall that document?-- I do.

There was a reference in that for the need to recruit further consultants in orthopaedics?-- Yes, I do.

And for the need for teaching sessions to be introduced if consulting staff could be employed?-- Yes, I do.

And that there was a hope to obtain - by doing that to gain teaching accreditation for the hospital at some time in the future?-- That's correct, yeah.

And it was not the case, as was put to you, I suggest, doctor, that you and Dr Hanelt were content to maintain the status quo of the orthopaedic department as it was and - as it was in January 2004?-- No.

It was in fact the intent to increase the number of specialist staff when those staff became available?-- That's correct.

The ideal discussed by you and Dr Hanelt was two staff specialists and two visiting medical officers?-- That's correct.

And that was the goal that was hoped to be achieved by recruitment of professional staff?-- That's correct.

Are you aware that generally there is the staff - generally the Hervey Bay Hospital operates at about 75 per cent of its medical staff, or aren't you able to comment on that?-- I am unable to comment.

All right. Are you aware that there is a constant placement with recruiting agencies by the Hervey Bay Hospital of a need - or an advertisement of a need for orthopaedic staff at the hospital?-- Yes, I am aware.

Very well. You were asked some questions this morning about leaving the SMOs to perform orthopaedic work, be it clinical

or surgical work, at the hospital when you were away on leave and another specialist was not available. Do you recall that?-- Yes, I do.

It was put to you that it was unacceptable that the SMOs were left unsupervised by you at times when you weren't available or other consultants when they weren't available. Do you recall that?-- Yes, I do.

Could I suggest to you that while that may have been unacceptable, it was a situation where you had a degree of trust in Dr Krishna and Dr Sharma in the performance of their work?-- Yes, I did.

You had a degree of trust in their judgment as to what they could comfortably handle by way of orthopaedic problems?-- Yes, I did.

And if either of those two senior medical officers were uncomfortable, you were confident that they would do as instructed, I suggest; contact consultants at the Royal Brisbane Hospital-----?-- Yes, sir.

-----or at Nambour Hospital?-- Yes.

Or Dr Mullen, for example, if he was available?-- Yes.

Or you if you were available?-- I was usually not in the district when I was on call - when I was not on call, sorry.

And they could also contact Dr Khursandi and speak to him?-- That's correct.

It is the case, isn't it, that over the last five years leading up to the present time, the number of orthopaedic admissions to the Hervey Bay Hospital amounted to about 1,100 per year, is that the case?-- Um-----

Or aren't you able to comment on that?-- I am unable to comment on that.

Very well. It is the case, is it not, that in many circumstances where a consultant is not available and the senior medical officers are not able to deal, for example, with an orthopaedic trauma that comes to the hospital, that those cases are evacuated to another hospital or through the retrieval system or simply transferred, for example, to Nambour?-- Yes.

They could either go to Prince Charles Hospital or Royal Brisbane Hospital?-- Depending on the nature of the injury. If it was a spinal injury they would go to Princess Alexandra Hospital. If it was a general trauma they would go to Royal Brisbane or Nambour.

And it was the case, wasn't it, that you trusted Dr Krishna and Dr Sharma to make a confident judgment as to what they could handle and what they could not handle in the absence of

direct supervision by a consultant?-- Yes, I did.

Very well. You were asked some questions earlier about patient P430, I think, the unfortunate lady who ended up having her arm amputated. Do you recall that patient?-- Yes, I do.

Could I put to you that Dr Hanelt had occasion to speak to you about that patient after Dr Mullen became involved in her treatment. Do you recall that?-- Yes, I do.

He, for want of a better word, perhaps, admonished you to this degree: he expected you to notify the likes of Dr Mullen in circumstance about a patient like P430 and, in particular, P430 , in circumstances where you were going to be absent while she was admitted to the Hervey Bay Hospital?-- Yes, he did.

And the admonishment was he expected you to, in effect, hand over that patient by informing Dr Mullen of her condition and needs while you were absent?-- Dr Mullen wasn't always available.

No, I understand that-----

COMMISSIONER: Did you-----

MR McDOUGALL: Listen to my question perhaps.

COMMISSIONER: Did he do that or not? Just listen to the question?-- Could you repeat the question?

MR McDOUGALL: I suggest to you the admonishment Dr Hanelt gave you was that he expected you, in circumstances where you had a patient like P430 , and in particular her case, to, in effect, hand over to Dr Mullen her care by informing Dr Mullen of her needs and her condition and the fact that she was an inpatient in circumstances where you were not going to be present and maintain your treatment of her?-- Yes, sir.

COMMISSIONER: Is this admonishment before or after the event, Mr McDougall? I don't understand the question, really.

MR McDOUGALL: I put it to the witness it was after Dr Mullen's involvement with the patient.

COMMISSIONER: I didn't hear that. Thank you.

MR McDOUGALL: And that was an admonishment that wasn't just restricted to P430's circumstances, was it; it was any patient like P430 that might be in her situation or similar situation that would require treatment and monitoring in circumstances where you weren't going to be there to continue that treatment?-- That's correct, sir.

You were also asked some questions about morbidity and mortality meetings, and you make a distinction between two sorts of meetings: one, a morbidity and mortality meeting

that was held quarterly where a large number of matters were discussed, and a weekly meeting where your particular group, the SMOs and yourself, or any of the orthopaedic staff, would review all patients dealt with in the week prior. Do you recall that distinction you made?-- Yes, I do.

It was the case, wasn't it, that until the - well, you may or may not know about this so I will phrase it a different way: it wasn't until fairly recently - and I can't be more precise about the date at this stage - that the district became funded to arrange for the data collection necessary for the running of a morbidity and mortality meeting on a regular basis?-- That's correct.

And that involved the employment of staff to collect that data so statistics could be generated for morbidity and mortality meetings?-- That's correct.

But so far as the general review of patients admitted to the hospital was concerned, you did conduct the meetings amongst the orthopaedic staff dealing with each patient every week?-- That's right.

Now, if I could just take you to your statement at paragraph 2.15, you say, "The Director of Medical Services of the Fraser Coast District, Dr Terry Hanelt, was aware of my periods of hospitalisation for depression and of my diagnosis. I asked Dr Hanelt to keep my medical details private and as far as I am aware he abided by my request." Now, doctor, isn't it the case that in August 2004 you were away from work for about two weeks and the purpose of that absence from work was your hospitalisation?-- That's correct, yes.

It wasn't, though - you did not - well, I withdraw that. You may have told Dr Hanelt that you were going to be hospitalised but you didn't tell him you were going to be hospitalised for depression, did you?-- No.

You told him about a medical condition?-- That's-----

What was that medical condition?-- I told him I was having marital problems at that time and I was stressed.

I am sorry - well, did you tell him anything else?-- That I had colitis.

So - could I put this to you: so far as Dr Hanelt's concerned, he understood you were suffering from the condition ulcer of your colitis, which brought about your various needs - various occasions for hospitalisation?-- I do suffer from ulcer of colitis as well.

But that's what you told Dr Hanelt required your hospitalisation?

COMMISSIONER: He had no reason to think that you were going to hospital for any other reason than for colitis?-- My medical certifications that I went into the hospital didn't

come from the general surgeon, it came from a psychiatrist.

MR McDOUGALL: Could I suggest to you, though, Dr Naidoo, that what you told Dr Hanelt was that the condition that caused your hospitalisation and your absence from the hospital was this condition ulcer of your colitis?-- I recall telling him that, yeah.

I have nothing further, thank you.

COMMISSIONER: Thank you. Mr Perry? Perhaps Mr Farr first.

MR FARR: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FARR: Dr Naidoo, my name is Brad Farr. I appear, relevantly for your purposes, for Drs Krishna and Sharma. Can I ask you this: we know that in early July last year doctors North and Giblin came to the Hervey Bay Hospital and interviewed a number of people during the course of a day. Did they speak to you?-- Dr - are you referring to Dr North and Dr Giblin?

Yes?-- Yes, they did, and I recall they spent about half an hour with me in the morning.

Right?-- And about five minutes, or thereabouts, towards the end of the day.

During the course of your discussions with them were you asked to give them an opinion as to the clinical capabilities of. Drs Krishna and Sharma?-- Yes.

And did you do so?-- I showed them the scope of service documents that I prepared.

All right. So they are the documents we have seen now in the inquiry?-- That's correct, yeah.

Did you offer them an opinion as to their skill levels?-- I wasn't asked about that.

You weren't asked?-- No.

So you gave them the scope of service documents. Was there a discussion then about those documents?-- There was no discussion at that time of the documents and I had no chance to review their report either.

Right. Did they take those documents with them or did you just hand them to be seen and then were they given back?-- I can't recall for certainty whether they took them with them or I sent it to them subsequently, yeah.

At any time after that day in early July when they spoke to people at Hervey Bay, did you have any further conversation with either Dr North or Dr Giblin on this topic?-- No, I didn't.

COMMISSIONER: Are you saying that they didn't ask you about Drs Krishna or Sharma, or you can't recall?-- I can't recall with certainty that they asked me specific questions about Dr Krishna and Dr Sharma.

Right?-- I recall that most of the questions were directed about myself, about the on-call roster, about audits, and about where I live but not - there were many clinical questions put to me as well.

Did you volunteer any information to them regarding either Dr Sharma or Dr Krishna's clinical capabilities?-- I wasn't specifically asked about it, no.

COMMISSIONER: Well, you said you can't recall whether you were asked or not?-- No.

MR FARR: So you weren't asked, or you don't know if you were asked, but do you remember if you volunteered any such information-----?-- No, I didn't.

-----without being asked?-- I didn't.

COMMISSIONER: Now, are you saying you can recall you did not volunteer or you can't recall whether you volunteered?-- I did not volunteer.

Sorry?-- I did not volunteer.

All right, thank you.

MR FARR: Thank you, that's all I have.

COMMISSIONER: Thank you. Mr Perry.

MR PERRY: Thank you.

RE-EXAMINATION:

MR PERRY: Mr McDougall was asking you about your hospitalisation and you referred to medical certifications. Annexed to your supplementary statement are some certificates from Dr Christensen. Are they the certifications you were referring to?-- That's correct, yeah.

His qualifications describe him, by the letters used, as a psychiatrist?-- That's correct.

How were those certifications supplied to the hospital?-- With my leave forms.

Thank you. As to P430 , there were three alternatives, I think you said, at the time of your operation on her, plaster, plate or external fixateur?-- That's correct, yes.

Why did you not choose to use the external fixateur at the initial stage?-- Because I expected the same outcome that she would after Dr Mullens did the external fixateur because she was quite restless, agitated and plucked at everything that she could.

That is a patient interfering in the manner that this lady already did with a external fixateur had the potential for significant damage to the arm?-- That's correct.

In terms of the young man P446, you know of criticism about the length of the screws used by you and you responded that there was a special type of plate that you used which justified those screws; what did you mean by that?-- I used a plate called a proximal tibial plate which is manufactured by a trauma company called Sinthes, and my assessment at the time was that the fixation with regard to the plate and screws was satisfactory holding the fractured fragment that I'd fixed.

Thank you. Now lastly, Ms McMillan asked you some questions about you doing ward rounds and then suggested to you that she could find no note of your attending or reviewing a particular patient; do you recall that?-- That's correct.

What is the position, that you have a recollection of doing the ward rounds?-- Yes, I do.

All right. Is it uncommon for there to be no specific reference to such an event in the clinical note that might be prepared by another party?-- That's not uncommon.

Thank you.

COMMISSIONER: Sorry, do you have a recollection of doing a ward round on that day?-- Yes, I do.

I see. All right.

MR PERRY: I think in fairness, sir, that his answer may have been to the extent of whether or not it was in the note or not and he accepted that it was not rather than whether or not he had made a ward round that day which is why I asked him that question.

COMMISSIONER: Mmm.

MR PERRY: Thank you, that's all I have.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No re-examination, Commissioner.

COMMISSIONER: Dr Naidoo, we may need you back, but in the meantime you're excused from further attendance?-- Thank you.

Thank you.

WITNESS EXCUSED

MR ANDREWS: Before calling Dr Hanelt, Commissioner, a member of the media brought to my attention that during the previous inquiry when witnesses were concerned not to be filmed, the camera was still permitted to remain in the hearing room and filming so long as it was not directed at the witness about for whom an application for privacy was made. I bring it to your attention that it is a possibility with respect to witnesses who bring applications.

COMMISSIONER: Thank you, we don't even know if Dr Hanelt wants to make such an application.

MR ANDREWS: No, quite so.

COMMISSIONER: All right, thank you.

MR ANDREWS: I call Dr Hanelt.

TERRENCE MICHAEL HANELT, SWORN AND EXAMINED:

MR ANDREWS: Good morning, Dr Hanelt. Is your full name Terrence Michael Hanelt?-- Yes.

Doctor, have you prepared two statements, the first of them signed at Hervey Bay on the 18th of August 2005, a statement with attachments numbering up to TMH 39?-- Yes.

Are the facts recited in it true to the best of your knowledge?-- At the time of making the statement they were true to the best of my knowledge.

And the opinions you expressed in it, are they honestly held by you?-- They were at the time of making that statement.

Are there some passages in that statement you particularly wish to correct?-- There are several paragraphs in relation to approval of leave and the subsequent search of documentation was brought into question.

And - well, I'm aware that you've supplied a further statement. Are the - and that's a statement of the 7th of October 2005?-- Yes.

Are the matters that you would change in your first statement matters that are canvassed in your five page statement of the 7th of October 2005?-- In relation to the leave, I believe they are.

I tender the statement, the earlier of the two statements.

COMMISSIONER: Yes.

MR ANDREWS: Being your statement of the 18th of August 2005 with annexures.

COMMISSIONER: Yes. You're going to tender them separately, are you?

MR ANDREWS: I'm happy for them both to be given the same number, but I'd like to clarify a matter about that statement before tendering the second.

COMMISSIONER: All right, yes.

MR McDOUGALL: Actually, Commissioner, I have the originals of those two statements, the signed originals, so I presume I'm to hand them up at this stage.

COMMISSIONER: I suppose so.

MR ANDREWS: If that's convenient.

COMMISSIONER: We're happy to accept copies, of course, but thank you very much.

MR ANDREWS: I tender the original of that statement.

COMMISSIONER: All right. That will be Exhibit 444.

ADMITTED AND MARKED "EXHIBIT 444"

MR ANDREWS: What else within that statement, doctor, would you like to correct that has not been relating to the leave matter corrected in your second statement?-- The other matter could have been if I was making that statement at this stage in relation to an audit done of the fuel dockets for Dr Naidoo's car, in the statement it says that the analysis is incomplete. It is still incomplete but there's certain discrepancies that would require further explanation.

Thank you. In the circumstances, I tender, Commissioner, and ask that it be given the same number, Dr Hanelt's statement of the 7th of October 2005.

COMMISSIONER: Thank you. That will be also Exhibit 444.

ADMITTED AND MARKED "EXHIBIT 444"

MR ANDREWS: Dr Hanelt, as Director of Medical Services, you'd have been given a position description by Queensland Health?-- When I was originally appointed to the position, I believe I was.

I haven't got a copy of yours, although I do have a copy which is Dr Keating's for the Bundaberg Health Service District, I'll put it on the monitor and ask if you recognise some of the duties for the Director of Medical Services. Now, you'll see that this doesn't relate to your health service district but its review date is October 2002 and it's a Queensland Health document?-- Yes.

Would you move to the second page? Among it on the second page there are shown to be some duties and some reporting relationships. Is it or was it your understanding that while you were Director of Medical Services at Fraser Coast, you had a reporting relationship with the district manager at the Fraser Coast Health Service District?-- Yes.

Which required continual consultation between you?-- Yes.

Would you show me the primary duties and responsibilities? Would you, like the Director of Medical Services at Bundaberg, have been obliged to contribute to the planning processes of clinical services?-- Yes.

To assist the district manager in strategic and operational planning and medical workforce planning?-- Yes.

To monitor clinical outcomes and standards?-- Yes.

And to participate in the implementation of policy relevant to clinical services?-- Yes.

Is there something on the next page? And was it your duty to oversee maintenance of medical quality improvement programs and to participate in relevant internal quality improvement exercises?-- Yes.

And was it also one of your duties to attend to applying to Queensland Health - I beg your pardon - to the Medical Board of Queensland when seeking the registration of a potential overseas-trained graduate?-- Yes, for overseas-trained graduates, we had to make application to both Queensland Health and to the Medical Board.

Would you apply to Queensland Health to seek a determination that there was an Area of Need for an overseas-trained doctor?-- That's correct.

With respect to Dr Sharma, I have an Area of Need position description Form 1 I'd like you to look at on the monitor. It's part of Exhibit 361. Now, you recognise that sort of form, don't you-----?-- Yes.

-----as a typical one. There's an initial where it says "Signed on behalf of employer"?-- Yes.

Do you recognise the person initialing?-- That's my initials, that would be a copy of the original form.

Now, I see at the bottom it says, "Dr Sharma is known to a Senior Medical Officer currently employed by this district". Now, that would have been a reference to Dr Krishna?-- It may have been Dr Krishna or it may have been another Fijian-trained doctor that we had working at the hospital at that stage.

Well, from that comment, will you accept from me that this is a form likely to have been produced by you in about January 2003 prior to the creation of the Area of Need for Dr Sharma who began some months later?-- Yes.

Now, the supervision that you were indicating would be available was supervision by a staff specialist in business hours; who was that?-- That would be Dr Naidoo primarily.

And who was to supervise as necessary after hours?-- The after hours supervision would be provided by either a local orthopaedic surgeon or a distal orthopaedic surgeon.

Well, in 2003, as I recall, Dr Mullen wasn't providing after hours care, was he?-- No, Dr Mullen-----

That is, on-call?-- Yes, that is the same thing.

Thank you. Was he or was he not?-- Yes, Dr Mullen was on-call within the district from when he commenced duties in 2002, I think it was, about September perhaps through until his resignation in May of 2005.

And he was on-call how many nights per month?-- His rostered or the planned roster was one night per week and one weekend in four.

Thank you. Who was providing the as necessary supervision after hours when Dr Mullen was not on-call?-- If Dr Mullen was unavailable and Dr Khursandi was unavailable and Dr Naidoo was unavailable, then supervision was by contact with other orthopaedic specialists at other hospitals.

You said distal supervision?-- Yes.

Does that mean ringing the Royal Brisbane Hospital or the Princess Alexandra to speak with a consultant there?-- Be ringing a different hospital depending on the nature of the matter, whichever was the appropriate hospital to contact.

A person reading the supervision available section would ordinarily assume that it meant that actual physical, that is, proximate supervision by an orthopaedic specialist would have been available during all business hours?-- That would be a reasonable assumption.

And whenever a patient had to be treated after hours?-- I wouldn't consider that a reasonable assumption.

COMMISSIONER: You wouldn't?-- No, it's widespread throughout Queensland that there are Senior Medical Officers who work independently after hours without supervision, without direct supervision.

MR ANDREWS: But does it not say - isn't there a column about the available supervision and does it not say "as necessary after hours"?-- Yes. The Medical Board has now got to the stage of defining there's four separate levels of supervision and one of those levels is remote supervision.

Well, do you say "remote supervision" there?-- No.

COMMISSIONER: But does that mean that you thought remote supervision was sufficient?-- Yes.

Whenever these other doctors were not available and whatever the Senior Medical Officer was doing at the time?-- The Senior Medical Officers were assessed as competent doctors who would do stuff - or do procedures that would make decisions within their capacity and capability.

How were they assessed? Not by a credentialing and privileging committee?-- No, there's no mechanism with

credentialing and privileging-----

No, no, they weren't assessed by credentialing and privileging committees, were they?-- No.

How were they assessed?-- They were assessed by Dr Naidoo.

I see.

MR ANDREWS: Let me look at the next line. "Consultant advice available." It appears that consultant advice and/or assistance is available 24 hours a day seven days a week. Doesn't that suggest that there was - there would be a consultant on-call whenever the VMO - the SMOs were on duty?-- It is certainly not meant to suggest that.

But that's what - well, whatever you meant I'll leave to one side. A person reading that would assume that a consultant was proximately available, that is, within 30 minutes of the hospital whenever the SMO was on duty?-- I don't accept that.

COMMISSIONER: You say that includes remote consultant advice?-- Yes, there's no requirement for any SMO to be available within 30 minutes or any consultant to be available within 30 minutes.

MR ANDREWS: Why did you not insert "remote advice" as opposed to remote - yes, why didn't you insert "remote advice"?-- Did not occur to me as being necessary at the time.

Wouldn't it be the case that anywhere in Queensland that there's a telephone, one could always fill in both the "Supervision Available" and "Consultant Advice Available" columns with what you've inserted if they mean nothing more than remote advice?-- Yes.

COMMISSIONER: So, if you were the medical superintendent of the Thargomindah Hospital, if there is such a hospital there, that's the way you'd fill it in?-- I would not be recruiting a position such as this for the Thargomindah Hospital, so I'm unable to answer that.

It seems very odd to me, doctor.

MR ANDREWS: Do you concede that there's a capacity for improving the way you express yourself in that form to make it clearer to the reader precisely what you mean?-- Yes.

Wouldn't it have been appropriate, for instance, when filling in that form, to say that for some of the year there would be only remote supervision available?-- That could have been included.

COMMISSIONER: Should have been included in retrospect?-- In retrospect, certainly would place it in the newly developed forms at the stage, the new forms require-----

But in retrospect, it should have been included at the time,

wouldn't you think?-- Yes.

MR ANDREWS: And "24 hours a day, seven days a week" seems to refer to assistance as opposed to advice; do you see that in the last of the columns?-- Yes, "Consultant advice and/or assistance available".

Well, because it was so difficult for you to have continuous specialist orthopaedic care, because, for instance, Dr Naidoo had to have holidays, it was inaccurate to say 24 hours a day, seven days a week, wasn't it?-- If it said, "Consultant assistance available 24 hours a day, seven days a week", it would be inaccurate.

When Dr Sharma was appointed, you received a letter from the Medical Board a copy of a letter that went to Dr Sharma advising you that he wasn't registered as a specialist?-- I don't particularly remember receiving that but I expect I would have because it was normal procedure.

You at no time believed that he was registered as a specialist?-- I knew he was not registered in Queensland as a specialist.

And at no time did you believe Dr Krishna to have been registered in Queensland as a specialist?-- No.

COMMISSIONER: Or anywhere else in Australia?-- No, not in Australia.

MR ANDREWS: Would you look please at another Form 1; you had to apply annually for Area of Need certification, didn't you?-- Yes.

This is the one of the 12th of November, I think it's 2003 - I'll be reminded when it appears on the screen. Yes. That's your signature?-- That's my signature, I'm unsure whether that's November or April.

Yeah, it looks like April, but you can see at the bottom the comment, "Dr Sharma's worked for the district since January '03 and has demonstrated himself to be competent to perform at this level". This would be likely to be your second application for Area of Need with respect to his position, wouldn't it?-- Yes.

And it would be efficient for you to have made application somewhere about November at the end of that year, wouldn't it?-- Yes.

And if you look at the "Supervision Available" column, "Supervision by staff specialist business hours and most of the time after hours." Well, that was inaccurate, wasn't it, that he was supervised most of the time after hours?-- At the time of filling that in I believed that he was had supervision available most of the time after hours because it was my belief that Monday to Friday Dr Naidoo was in Hervey Bay and of a weekend two out of four weekends there was a consultant

on-call.

COMMISSIONER: And the other two?-- The other two weekends there was no consultant on-call.

So he wasn't supervised on those weekends?-- Yes, if he was the Senior Medical Officer on-call on those weekends, there was no supervision available in town.

MR ANDREWS: How often would Dr Naidoo - on-call from November 2003, was he on-call Monday to Friday week after week?-- No, it was - he was not on-call, but when he was in town he made himself available if the SMOs chose to contact him. Now, I'm unsure how much of the time he was in town.

Yes. Do you mean he had no duty to respond to them but if they rang him or made contact, you expected that Dr Naidoo would try to make himself available?-- Yes, that was my belief.

Did you discuss with Dr Naidoo your ambition that he'd be effectively on-call five nights a week?-- A discussion with Dr Naidoo was that he would do a - participate in the after hours provision of on-call equal basis with the other specialists and when he was in town available, he would make himself available to SMOs if they required advice.

COMMISSIONER: Did you have the impression that that occurred?-- Certainly there were times when Dr Naidoo was not on-call that I was aware that he was called by the SMOs to provide assistance and I was not aware of times where he was in town that he was unwilling to provide advice or assistance.

MR ANDREWS: The fact is that after hours if he wasn't rostered to be on call, Drs Naidoo and Krishna did everything themselves, didn't they?-- Dr Sharma and Dr Krishna.

Dr Sharma and Krishna, thank you?-- They certainly did not do everything themselves.

COMMISSIONER: How do you know?-- There are multiple orthopaedic procedures that can be performed that were not performed by either of those patients - either of those doctors on patients that presented.

But they performed all the ones which were mentioned as approved by Dr Naidoo on the Scope of Authority document, for instance?-- I am unsure if they performed all of them. Certainly they performed many of them.

Any of those that came in?-- Yes.

MR ANDREWS: If a person is rostered on call, they get paid for it, don't they?-- Yes.

So, do you mean that you were requiring Dr Naidoo to be available five nights a week on call without actually rostering him on call for those five nights a week and paying him for that?-- No. That's not what I'm saying. What I said was Dr Naidoo was willing to be contacted to provide advice if he was available.

Well, the supervision available ought it to have said, "Supervision by" - I beg your pardon, it ought to have said, "Staff specialist within the Fraser Coast Health District during business hours and on call one night per week." That's what it ought to have said?-- I believe that would not be a true reflection of the situation.

How would you change it to make it a true reflection?-- Well, one could say, "Supervision during business hours by staff orthopaedic whilst not on leave and by VMO when available and after hours by staff specialist one night per week and one in four weekends and by one night in five plus one weekend in four and available from Royal Brisbane Hospital or Nambour or Bundaberg as required."

So, really, you ought to have said, if you wanted to make it abbreviated, "After hours, mostly no supervision"?-- "No direct supervision".

COMMISSIONER: Well, for most of the time none by staff specialists?-- Yes, no direct supervision, I agree.

And very little indirect supervision. That was the reality, wasn't it? Dr Naidoo was almost never available after hours?-- Without having all the documentation of exactly when he was available and when he wasn't available, which is included in my statement, there's - his periods of on call were more significant than any of the other orthopaedic surgeons in the district.

MR ANDREWS: May I see the - would you exchange documents with me. You see on the screen an extract from the Medical Board of Queensland dated the 24th of April 2003 relating to an Area of Need Certification. Would you look at the next - the page with the flag on it and tell me whether you recognise it to be a document relating to Dr Krishna, a Form 1 signed by you that would have been created in about April of 2003?-- Yes.

And again do you certify that a staff specialist was available in business hours and as necessary after hours?-- That bears my signature.

I tender that one page from that number of pages being a Form 1-----

COMMISSIONER: Yes.

MR ANDREWS: -----relating to Dr Krishna created in about April 2003.

COMMISSIONER: That will be Exhibit 445.

ADMITTED AND MARKED "EXHIBIT 445"

MR ANDREWS: In your list of duties, you were aware that the District Manager had a responsibility under a Queensland Health policy for setting up a credentialing/privileging committee, weren't you?-- Yes.

And is it right to say that you with your own duties had a responsibility to consult with the District Manager about these things?-- Yes.

And you had - you were aware that no committee had been set up, no credentialing/privileging committee was set up until certainly some time after 2004 was over?-- There was a Credentialing Clinical Privileging Committee that was set up when I first commenced in the district under its former name 11 years ago, so in '94 under the previous policy of Queensland Health. When the policy changed, the committee changed because it was required to be processed under the Rural and Remote Hospitals Credential Committee. When the policy again changed, we attempted to set up a Privileges and Credentials Committee.

Doctor, you knew that there was an absence of a Credentials and Privileges Committee at the hospital for how long? When did it disband?-- When the Rural and Remote Hospital Clinical Privileging Policy was signed by Dr Stable, which I believe was probably 2001, but unsure of the date. I haven't been able to find a dated copy of it.

At least by July 2002 there was another Queensland Health

policy with respect to credentials and clinical privileges that had been published?-- Yes.

You were aware that it affected the Fraser Coast Health District?-- Yes.

You were aware that District Managers were responsible to ensure that all medical practitioners operating in the health service district had their credentials and clinical privileges periodically reviewed?-- Yes.

And that they were responsible for ensuring that there was a process in place in the district to allow that to happen?-- Yes.

You were also aware that all medical practitioners using a Queensland Health facility were responsible for completing and submitting an application form for the review of his or her credentials and clinical privileges by the relevant Credentials and Clinical Privileges Committee?-- Yes.

And that didn't apply just to Drs Sharma and Krishna, it applies to even you?-- Yes.

I see from your CV that you have some privileges in orthopaedics?-- Yes.

When did you obtain those privileges?-- I obtained those through the Rural and Remote Privileging Committee. Unsure of the date.

That would have been many years ago?-- It was when that policy was in force, which ceased to exist in July 2002.

Would that have been many years ago?-- Somewhere between three and five years ago.

And who privileged you?-- I made application to the - to that committee and members of that committee. I am unsure of - I only knew who the chairperson of that committee is.

You also have some obstetric and gynaecological privileges?-- Yes.

When were you privileged in that respect?-- The same time.

Have those privileges lines been updated since?-- No.

Well, they ought to be, ought they not?-- I need to reapply for clinical privileges if I recommence doing clinical work.

I see. Yes. Your CV, which is attached your statement, suggests that you still hold those privileges. Is it out-of-date now?-- That CV was current, I think, in January this year.

I see. You understood at all times that Drs Sharma and Krishna were employed that they were not privileged?-- Yes.

And you understood at all times that they were employed that they ought to have been privileged?-- I believe that they should have been privileged.

Did you bring it to the attention of the District Manager that it was his, that is Mr Allsop's responsibility - it is Mr Allsop who's the District Manager, isn't it?-- Yes.

That it was his responsibility to set up a committee?-- We were both aware of the responsibility. I don't believe I needed to bring it to his attention because he was aware. We discussed the matter.

And is it about May 2003 that was the first time you did anything about the fact that these two orthopaedic SMOs were not privileged?-- I don't recall.

Please have a look at this e-mail from you to Dr Darren Keating dated the 7th of May 2003, "Re clinical privileges."?-- Yes.

You saw it as a matter that had some priority because of the effect it might have on indemnity?-- That was certainly one of the aspects.

Well, was there another aspect, that it was of some importance to patient safety?-- Certainly has a relevance to patient safety.

And did you regard the lack of clinical privileges for persons such as Drs Sharma and Krishna as a matter relevant to patient safety?-- Yes.

COMMISSIONER: You can't recall whether or not that's the first occasion that you sought to do anything about it?-- Now that I have seen this document, I know it isn't.

Is it not? All right. How do you know from that document that it isn't?-- Because the Fraser Coast and Bundaberg Health Service Districts sought to amalgamate our clinical privileges processing because of the lack of success both districts had been getting in getting college representations to act on our committees.

Yes?-- And we didn't - Fraser Coast was - the majority of the specialities, we only have two specialists within that discipline, and to have those two giving the college input as - in relation to clinical privileges to me is not a viable situation where, "You decide if I'm okay. I'll decide if you're okay." There needs to be some unbiased practice. The majority of colleges failed to provide any representatives. Bundaberg were having a similar problem and after discussion with Dr Keating the decision was made that if we combine the two, we may get a big enough core group to be able to do the process without the college participation if they continued to decline to provide input.

Yes. Any privileging would have been better than none at all, wouldn't it?-- If we had done a process where, "I decide if you're okay. You decide if I'm okay", I would be criticised for that as well.

No, supposing, for example, we are talking about Dr Sharma and Krishna. If you had a privileging committee consisting of the orthopaedic specialist in Maryborough, Dr Mullen and Dr Naidoo, if you'd had that as your privileging committee, that would have been better than not having one at all, wouldn't it?-- I believe it would have been.

You didn't ever think to do that at the time - from the time either came to be employed until the end of the term of the orthopaedic department in Hervey Bay?-- The major problem was trying to get a college representative.

I understand that?-- When I couldn't get one, in hindsight, yes, we should have said, "Yes, I won't worry about the policy. We will simply do it contrary to the policy."

But it didn't occur to you at the time?-- Certainly not at the time.

All right.

MR ANDREWS: I have the advantage of your Exhibit TMH35, which I will put on the monitor. Would you look at the first page of this document. Do you see the top right-hand corner? Does it suggest to you that that's a document you created in 2002?-- It suggests it's a document I created. The number at the top corner I would have no idea what's that relevance, because it would have simply been a previous document that I typed input into.

So, well, is that - do you recognise that as your document?-- Yes.

Would you go down the page, please. At some stage the two health services, that's Bundaberg and Fraser Coast Health Service Districts, according to this policy statement combined to make the process more impartial for those being considered for credentials and clinical privileges. Do you recall when that combination occurred?-- I cannot remember when it was. It was some stage during the negotiation with Dr Keating from Bundaberg, and without my computer to see what date the file was saved, I don't know.

All right. Well, if Dr Keating's employment at Bundaberg commenced in approximately April 2003, would that mean that this document must have been created some time after that?-- Yes.

And you're the author of it?-- Yes.

In the outcome section, you speak of Senior House Officers?-- Yes.

What's the difference between a Senior House Officer and a Senior Medical Officer?-- The structure within the award is first year after graduation you are classified as an intern or post-graduate year 1 doctor. The second year after graduation you are a Junior House Officer, the third year after graduation you are a Senior House Officer, and you remain a Senior House Officer until you are appointed to some other higher position.

I see?-- But they're very juniors docs.

Thank you. May I see the second page, please. You recognised at least by the time you created this document that there was a need for the convening of a committee to recommend appropriate clinical privileges for Senior Medical Officers?-- Yes.

Have you ultimately seen such a committee convened?-- Yes.

When did that happen, 2005?-- I expect it was 2004 rather than 2005.

COMMISSIONER: The committee you had in mind involved a Director of Medical Services of each of the three hospitals?-- Yes.

None of whom might be qualified in the speciality of the person being privileged?-- Yes.

Did you think that was a good idea?-- It's required by government - by Queensland Health policy to have the Medical Superintendent of the institution on the committee.

You didn't intend that to be the only member of the committee?-- No.

I see.

MR ANDREWS: Would you look, please, at page 8 of the second part of Exhibit 279 under section 5.1. Was there as part of Queensland Health policy a requirement that there should be a core membership of practitioners constant for all applications for clinical privileges?-- Yes.

And a need to involve additional members having regard to the particular credentials of a particular applicant?-- Yes.

So, that if you were - if a core membership group was to grant privileges, for instance, in orthopaedics, it would have been appropriate to bring in orthopaedic practitioners to join that core membership for that particular purpose?-- Yes.

You would have been aware as Director of Medical Services that Dr Mullen didn't have time or opportunity - because of the rosters that he and the two SMOs had, he didn't have the opportunity to assess the duties that they performed; that is, to assess them in the performance of their duties?-- He would have been unable to assess them in all of the forms of duties

they performed.

They'd always be on call at the weekend?-- They would be on call-----

I beg your pardon?-- He would have been on call-----

The weekends that he was on call, they wouldn't be, and vice versa?-- Yes.

And they were very rarely in clinics with Dr Mullen?-- I do not know the answer to that. I haven't got copies of the schedules which vary from time to time.

By August of 2004 you would have been acutely aware that - because the Australian Orthopaedic Association had already been to your hospital, you would have been acutely aware that Drs Sharma and Krishan weren't properly privileged and you would have been wanting that to happen?-- Yes.

Would you look, please, at this e-mail. Do you recognise it as an e-mail sent by you to RN Dale Erwin, Dr Krishna, Dr Sharma and others?-- Yes.

This was relating to a period where Dr Naidoo Was going to be absent from the hospital for four weeks?-- Yes, or likely to be absent.

And is it the case that you were instructing Dr Sharma and Krishna that basically they could do anything they were happy with other than joint replacements?-- No.

What then ought they have understood you to have meant by that sentence I have marked in the orange highlight?-- That's to advise the theatre staff in relation to what they are allowed to put on the lists and what the SMOs would put in the list was in their assessed range of competencies by Dr Naidoo. In retrospect, that's poorly worded.

COMMISSIONER: So the nursing stuff might put things on the lists, but when it came to actually do the operation, one of them, Dr Sharma or Krishna, might say, "No, that's not within my competence"? You surely couldn't have meant that?-- It means the opposite - if they attempted to book anything - how it's - best way to explain it was that if Dr Sharma and Dr Krishna wished to book a case, then certainly - if they said something like a joint replacement, then that was not to go on a list where the other stuff should be okay, because - yeah, they were putting on stuff that was within their assessed scope of competence.

That's not what was said there?-- In retrospect, it was poorly worded.

It's not just not what you are saying now. It is something quite different. You are saying anything that Dr Sharma and Krishna are happy with, other than joint replacements, can gone on the lists. That's plainly what it says?-- Yes.

Now, you say that's not what you really meant to say?-- What they are happy with is what they have been assessed as competent to perform.

I see. All right. You left it to them?-- Certainly, it was left for them to-----

To decide what they were happy with?-- It read - literally that's what it says.

And not what you meant?-- It's stuff within their range of competence to perform, which is what they are happy to perform is what they are competent to perform.

You hope that would be the case, but you were prepared to let them do whatever they were happy with; isn't that correct? That's the way - that's the way it plainly should have been read and that's the way you intended it to be read. Is that not correct?-- It's not correct. What is meant as the - what's within their scope of service, that's what they are happy to perform, then that's what they should be allowed to book without reference to me.

Thank you.

MR ANDREWS: With the Director of Orthopaedics absent, it really was a situation where these two SMOs were - they were the orthopaedics department for most of that month, weren't they?-- Yes.

And they were left with a discretion to do whatever they wished other than joint replacements?-- They were left to do whatever's within their scope of assessed competence.

COMMISSIONER: Who was going to determine that? You weren't?-- That had been determined and documented by the Director of Orthopaedics.

All right. Did you ask them if they had copies of that document?-- No, I did not.

Did you know whether they had copies of that document?-- I do not remember whether I knew whether they had copies of that document or not.

MR ANDREWS: Would you put paragraph 6 of Dr Hanelt's first statement on the monitor? Weren't you aware that the Australian Orthopaedic Association's inspection at the hospital was in part because of concern about the assessed level of competence of the senior medical officers?-- Yes.

Well, when Dr Naidoo was absent, or anticipated to be, for a month, isn't it the case that if you left the doctors to do whatever had been assessed by Dr Naidoo as appropriate for them, you were leaving them to perform surgery in circumstances where you knew there were concerns about whether that level of competence was accurate?-- At that time I had the assessment of Dr Naidoo and he considered they were competent. Dr Mullen had questioned that the AOA had reviewed and they had not raised the issue with me despite being given the opportunity to do so.

COMMISSIONER: I don't think you have answered the question. Perhaps you better ask it again.

MR ANDREWS: You knew that there was disagreement plainly between the representatives of the Australian Orthopaedic Association and Dr Naidoo about whether the two SMOs were given too much responsibility?-- No, I was not. I was aware there was disagreement between Dr Mullen and Dr Naidoo. The Australian Orthopaedic Association had not provided input of some 10 months after the review before I got that input.

Thank you. Well, then, knowing that there was disagreement between two orthopaedic specialists about the level of competence of the two senior medical officers, weren't you particularly concerned that they were given the run of the orthopaedics department for a month?-- The difference of opinion was in relation to supervision rather than in relation to competence. The opinion of Dr Naidoo versus the opinion of Dr Mullen, I accepted the opinion of the person who was the more experienced, more senior orthopaedic surgeon.

Where there is a difference of opinion about supervision, isn't that because the persons to be supervised aren't competent to perform unsupervised? It is not just about whether there is a rule that's broken, but it is about patient safety?-- It is certainly about patient safety.

Well, weren't you concerned for that month?-- There was certainly concern if they did things that was beyond the scope of their practice, that there could be adverse outcomes.

COMMISSIONER: No, no, that's not the question. There was disagreement between two orthopaedic surgeons, Dr Mullen and Dr Naidoo, as to the expertise of these two doctors to perform operations which were within that scope of authority document. Weren't you concerned that until that was resolved, it would be dangerous to let those doctors perform all of those

operations?-- At the time it did not occur to me.

Right.

MR ANDREWS: And it is - well, in the absence of Dr Naidoo, the responsibility for these things fell upon you, did it not?-- Yes.

At paragraph 16 of that same statement you say, "The AOA would seem to have held the view that training provided under their name and resulting in a diploma under their seal was adequate to treat people in Fiji but not in Australia."?-- Yes.

Do you recall that? That suggests to me, as a reader, that you hold an opinion about whether the diploma is adequate for the treatment of patients in Australia?-- The intent of that statement is to question why the AOA considers the same training is not appropriate in two countries.

What's your opinion? Do you have one?-- No, I haven't formulated an opinion on that.

Is that a matter that's not within your area of expertise?-- Yes.

COMMISSIONER: I see it is after one o'clock.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: We will adjourn till 2.

THE COMMISSION ADJOURNED AT 1.05 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.00 P.M.

MR McDOUGALL: Perhaps if I go outside and hunt him up - no he is here.

COMMISSIONER: Someone else might be doing that. Save you the trouble.

TERRENCE MICHAEL HANELT, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Doctor, at paragraph 22 of your statement, you observe that "quality assurance activities within the orthopaedic service were inadequate but the necessary resources have subsequently been made available to remedy it"?-- Yes.

In what respects were the quality assurance activities inadequate?-- There are basically two forms of clinical audit, quality assurance - whatever term you prefer to use - that's utilised by most clinical areas. One is weekly meetings, review of current patients, patients that have been managed within that week, to make sure all results have been followed up to discuss alternative options, if the outcome wasn't as desired, how we might have done things differently. And then there is a system where you collate your outcomes so you can look at longer term trends. If you have something goes bad in one week, that doesn't necessarily mean that overall the service is bad. It may have been an unavoidable bad outcome but the collation of the results gives you an indication of time.

So you get to see the bigger picture if you have meetings less frequently that review general patterns?-- Yes.

Now, how were - thank you for identifying those two aspects of quality assurance. How were they inadequate before so that you can then explain how they are different now?-- Previously there was the weekly meetings which I described in my last answer, and the longer term review meetings were held quite infrequently, and basic reason for that was the lack of ability to collate the data.

So the - you mean that there were inadequate numbers of the longer term meetings?-- Yes.

The inquiry has heard in other evidence that at quality assurance meetings, whether of the short or the long-term variety, it is often the case that if they are to do with a particular discipline, like surgery or orthopaedics, you will often find a person from outside the public hospital is invited to attend and attends to give input?-- That's the ideal.

That wasn't happening at Fraser Coast, was it?-- There was no-----

Well, not for orthopaedics anyway?-- No orthopaedic surgeons in the district that weren't employed by the district.

Would it be fair to say - well, I beg your pardon, were you aware that there were tensions between Drs Naidoo and Mullen?-- Yes.

Now, you were aware that there was in fighting, were you, between Drs Naidoo, Krishna and Sharma before the email that you helpfully appended to your statement, TMH22, dated about the 18th of June 2004?-- I was aware of difficulties in relationship between Dr Naidoo and members of the staff, which was not specific to Sharma and Krishna, but certainly there was concerns with many quarters of the staff about his communication style.

Well, that ought to have been particularly acute for the

persons who were to be supervised by him, being the poor Drs Sharma and Krishna?-- I would expect it would have been.

What was it about his style that you understood to be difficult for those he supervised?-- Dr Naidoo tends to be rather abrupt in dealing with certain issues and - difficult to describe. I guess just the general attitude.

COMMISSIONER: Wasn't there also a problem between Drs Sharma and Krishna, on the one hand, and Dr Naidoo on the other, because of Dr Naidoo's absences?-- Certainly the - Dr Naidoo was absent for a lot of time. Whether there was conflict between them in relation to that, I am unaware.

There was concern from other members of the staff about Dr Naidoo's frequent absences?-- Yes.

Wasn't there?-- Yes.

When did you first become aware of that?-- I can't recall when I first become aware of it but it was certainly not a recent event.

What, you mean it was as early as 2002, 2003?-- It would have been at that, if not earlier.

Even earlier than that?-- Quite likely was.

So there had been constant complaints over several years about Dr Naidoo's frequent absences?-- Yes.

Complaints from members of the staff?-- Yes.

Did you do anything about that?-- Yes, we checked with HR in relation to what his leave entitlements were, and the report from HR was that the leave that he had taken, that he had applied for, were within his entitlements.

Did you check to see whether he was ever absent when he was not on leave?-- Absent when not on leave - there were times when it was reported to me that he couldn't be contacted. On those occasions I attempted to contact him. On the occasions that I attempted to contact him, there were a couple of times where I was unable to contact him, which, from memory, was instances like early on Monday morning when he should have been at work, contacted him on the mobile phone, he would tell me he had been held up in traffic on the way back from Brisbane and he would be back in the shop shortly.

Yes.

MR ANDREWS: Well, if you had attempted to discipline him - you really had nowhere to go if you disbelieved him because what could you do in your situation?-- Very difficult to keep track of staff when you are working over two campuses. I work over two campuses, Dr Naidoo works over two campuses. When people questioned where he was, some of the time he was on leave and they simply weren't aware he was on leave, other

times he was contactable but had not contacted him by appropriate means. If you are in the operating theatre your mobile phone must be turned off.

But hypothetically if you believed, for argument's sake, that Dr Naidoo was, from time to time, cutting corners with his time and not attending to his duties - if you had believed that, what could you have done in your supervisory role? Anything?-- Other than tail-tagging him, very little that I know of.

And if you had sacked him there was no-one else to replace him?-- Yes.

You mean you agree?-- Yes, I agree.

COMMISSIONER: There comes a point, I suppose, though, doctor, doesn't there, where the medical orthopaedic service which you are providing may become inadequate and unsafe?-- That's a difficult question to answer, because even if you have got no orthopaedic staff, you still have to provide an orthopaedic service. People turn up with broken wrists, with dislocated shoulders that have to be managed-----

Forget about emergency surgery for the moment. Put emergency surgery to one side?-- Elective surgery I would agree.

I beg your pardon?-- I would agree with elective surgery.

It never happened, though, did it, at Hervey Bay that elective surgery was suspended or discontinued?-- Not until May this year.

No, not until after the report was released?-- Yes.

Did it occur to you before then that you had reached a point where the delivery of an orthopaedic service, other than emergency one, was so inadequate as to be unsafe?-- No, it had not.

You think in retrospect it should have?-- In retrospect, after reading the evidence given by some of the other orthopaedic surgeons at this Commission, I believe there should have been further restrictions placed upon the procedures performed by the SMOs within the district whilst there was no direct supervision.

Well, that would have been achieved by the proper method, a proper privileging committee?-- I agree with that.

MR ANDREWS: The quality assurance measures, it would be reasonable to conclude that if Drs Sharma, Krishna and Naidoo had their relationships affected by the personality or management style of Dr Naidoo, that that would affect the utility of any weekly clinical audits?-- That certainly would affect the openness with which they were conducted, as with the differential power gradient between Dr Naidoo and the SMOs.

Do you mean he was on top and they were-----?-- He was the boss.

Yes. At paragraph 27 of your larger earlier statement, you say that, "Clinical concerns, they" - meaning the Australian Orthopaedic Association - "raised had been resolved by the time the report was released." Now, as I understand it you had - some things had improved. You had Dr Kwon and Dr Kwon was energetically accepting the responsibility of being on call for a huge proportion of the time. That's correct?-- Yes.

Well, that was a significant improvement, wasn't it?-- Yes, that allowed us to provide a specialist orthopaedic service the majority of the time.

And were you aware that Dr Kwon was actually supervising both Drs Sharma and Krishna for everything?-- I believe he was supervising them for everything initially.

And that the only times Dr Kwon was not on call were occasional weekends?-- Yes, it was one or perhaps two weekends during the four months, I think, that he was there.

Well, that resolution can only have been a temporary one. Dr Kwon couldn't have been expected to maintain that workload, could he?-- Dr Kwon was only there for a maximum period of six months.

COMMISSIONER: But he couldn't have been - no doctor could have maintained that workload?-- It is unsustainable workload. Dr Kwon wished to do that amount of on call. He was heading overseas and it helps the wallet.

But it would have been unsafe to provide a service in which that had not occurred?-- I am sorry, Commissioner?

It would have been unsafe to provide a service where these doctors were not supervised all of the time?-- It is unsafe if they do things that's beyond their competence.

And you knew, at least by then, that they had been doing things beyond their competence and that they, because they had never been credentialed or privileged, needed to be supervised, at least initially, all of the time?-- Certainly when Dr Kwon came on board we already had the concerns that had been raised. Dr Kwon had not seen either of these surgeons previously, so he supervised them until he could make his own assessment of what they were competent to do independently and what they were not competent to do independently.

But my point is that you knew by that time that that was necessary; that is, that there be an orthopaedic surgeon supervise these two doctors constantly until satisfied as to what operations they could perform?-- Yes, I would agree with that.

MR ANDREWS: One of the concerns raised by the North Giblin Report that wasn't resolved at the time, even when Dr Kwon was present, was the recommendation that there be two staff specialists and two VMOs, being a body of four orthopaedic specialists?-- Yes.

And they weren't recommending that as the gold standard; they were recommending that as the minimum to maintain an orthopaedic department?-- Yes.

And one can't include Dr Khursandi because he wouldn't leave Maryborough, would he?-- Yes, that's correct.

So even by the time of the North Giblin Report's publication, you still had the problem that you couldn't get orthopaedic specialists in sufficient numbers to come to Hervey Bay?-- Yes.

Which leads me to what appears at paragraph 32 of your statement to be touching upon an interesting dilemma for administrators of the hospital. You say, "When it is not possible to recruit an adequate number of specialists to provide a continuous specialist service, as has been the case in the Fraser Coast Health Service District, other models of service delivery must be utilised."?-- Yes.

Now, it would be the case that for certain - let me use a hypothesis - neurosurgery, it may be the case that there will be trauma patients who sustain injuries very close to the Hervey Bay Hospital whose injuries involve neurosurgical problems?-- Yes.

Neurological problems. Now, you won't - you can't afford to set up a neurosurgery department?-- No.

You would transfer those patients even though it would be perhaps in their best interests if there were a neurosurgery department at Hervey Bay?-- The majority of those patients are transferred. On occasions it is necessary to do bur holes in a place like Hervey Bay and I cannot recall any being performed at Hervey Bay but certainly there has been bur holes performed at Maryborough Hospital.

And bur holes are the drilling of three holes in the cranium to relieve the pressure of bleeding inside?-- Basically, there is a clot around the brain somewhere. You try to localise it and relieve it, depending on how many holes you would need to drill.

That's a kind of emergency neurosurgery that will have to be attempted to save the life of a patient in time to time?-- Yes. If you transfer the patient the patient is dead. If you attempt it, the patient has some chance of living.

Now, orthopaedic surgery is different in the sense that elective orthopaedic surgery is seldom likely to be life - I beg your pardon, the decision to transfer is unlikely to be

life threatening?-- By definition.

With respect to emergency orthopaedic surgery, what would be the practical consequences of closing down, as happened, the orthopaedic department in the Fraser Coast Health District? What happens to the emergency orthopaedic patient when the department's closed?-- The patients that cannot be managed by - I will start again. Some patients have got relatively simple injuries, such as a dislocated shoulder or dislocated finger, that the emergency department staff normally manage and happily manage. You get some patients who get a fracture that needs internal fixation. Those patients are currently transferred out unless we happen to have one of the visiting orthopaedic surgeons in the district at the time, or they are transferred to Maryborough hospital if Dr Khursandi can provide the service, and those patients don't suffer any damage other than the pain of transfer. And there are some patients that have compound injuries, which is where the bone has threaded through the skin, potentially contaminated, and those patients' transferring to alternate sites increased the risk of infection at the fracture site. We have another group of patients where the optimum is to treat them within a set time-frame. We were experiencing patients who aren't being able to be transferred to an alternate site within that time-frame. For example, fractured neck or femur should be internally fixed within 48 hours to get the optimum outcome. There is one patient of whom I am aware who sat in hospital for five days awaiting a bed in Brisbane.

COMMISSIONER: Waiting for?-- A bed to become available so we could transfer the lady.

MR ANDREWS: A bed in Brisbane, I think was-----

COMMISSIONER: Yes. But what if there were no beds available at Hervey Bay and you still have the orthopaedic department there?-- If there was no beds available.

Mmm?-- If there was no beds available, then we would be looking for an alternate site to transfer the patient.

So that might be Brisbane then anyway?-- Yes.

MR ANDREWS: At paragraph 35 of your report, you quote a section of the North Giblin Report, that the orthopaedic and fracture clinics were not always supervised by a registered orthopaedic specialist and much of the work was done by the SMOs, and you respond, "The fracture clinics at Hervey Bay Hospital were normally done in conjunction with the orthopaedic clinic." Well, that would have brought, would it not, Dr Naidoo into close proximity with the SMOs?-- Yes.

But he'll have been busy in his clinic and they'll have been busy in theirs?-- Yes.

And an appropriate standard of supervision would be for the specialist actually to be available in the same clinic as the SMOs, with exceptions?-- Within the same area within the

specialist clinics within the hospital, as happens in every other hospital I have ever worked in. When I was a registrar in obstetrics and gynaecology, I would do my clinic, the consultant would be doing their clinic, and patients you wished to discuss with the consultant you would catch him between cases.

You don't dispute, I understand it, the notion that the amount of leave that Dr Naidoo was taking, because of the situation where he was the only staff specialist and because you didn't have a band of available VMOs, that his leave resulted in unacceptably long absences of a specialist from the hospital? You would agree with that, they were unacceptably long from the point of view of the orthopaedics department?-- They weren't ideal because when he was away the level of the orthopaedic service had to drop.

COMMISSIONER: Well, not just not ideal; inadequate?-- I feel the term inadequate I am having difficulty with because you are providing a service in orthopaedics irrespective of whether you have a consultant or not, you have no choice, but to-----

Oh, well, leave - I perhaps didn't phrase that as well as I could have. Leaving emergency work on one side, they were inadequate?-- Certainly there is inadequate coverage for any major elective orthopaedic work.

Anything except orthopaedic work which was plainly, that is on some objective judgment, within the competence of Dr Sharma or Dr Krishna?-- Yes.

Doesn't that mean that it was an unsafe service?-- It is unsafe if they're doing work that's beyond their level of competence without adequate supervision.

You know now that they were?-- Certainly the evidence provided by other orthopaedic surgeons here supports that there was some of the procedures they were performing that there wasn't adequate evidence of that their assessment - their competence assessment had been appropriate.

You don't dispute that now?-- No, I certainly do not dispute that now.

So at least in retrospect it is plain that the service which - the orthopaedic service which was being provided at Hervey Bay, at least during the absences of Dr Naidoo, was inadequate and unsafe?-- Yes, I will accept that.

And if Dr Naidoo did not supervise those doctors during the times when he was in fact on duty, then it was an unsafe - inadequate and unsafe system then also?-- If he failed to supervise them, yes, it would be.

Yes.

MR ANDREWS: You say of Dr Naidoo's competence at performing

total joint arthroscopies that you've only heard good reports in relation to this aspect of his work?-- Yes.

That's at paragraph 38. From whom did you hear those good reports?-- From the theatre staff that work with him and the various medical staff that work with him.

So it won't have been from one of his orthopaedic peers?-- Not from direct observation of his orthopaedic peers.

Thank you. At TMH16 there is an email from a clinical nurse manager, Kris Wyatt, who speaks of Dr Naidoo's technique as always being meticulous in that nurse manager's opinion?-- Yes.

The nurse manager, I assume, has only nursing qualifications?-- Yes.

That same person writes that he or she would be the first to admit that communication was less than ideal and that supervision of the SMOs was a serious issue?-- Yes.

Was that a thing that was - were you aware that was well-known to members of the nursing staff?-- I was aware that Dr Mullen had concern about the supervision of the two SMOs.

Did you only learn after the review had begun that there were other persons concerned about such things?-- To the best of my recollection, yes.

COMMISSIONER: You knew that neither Dr Krishna nor Dr Sharma had any respect for Dr Naidoo?-- They certainly had respect for his surgical ability. As a individual or as a person, unsure as if they had significant respect for him.

Well, you were told by Nurse Dale Erwin in June of 2004 that that was the case?-- Yes.

Did you accept that that was so then by then?-- At that stage it was when the concerns in relation to how he had been viewed by other staff certainly became a concern of mine.

And did you accept that that was so then?-- Well, if-----

That by then, neither of the SMOs had any respect for Dr Naidoo?-- I would not accept that they didn't have any respect for Dr Naidoo, no.

All right.

MR ANDREWS: Clinical Nurse Manager Wyatt also wrote to you in the same e-mail in May 2005, "I think perhaps because MNAI" - that will be Morgan Naidoo?-- Yes.

"Is such a difficult person to work with due to his poor communication and interpersonal skills and also inconsistent clinical and administrative management practices, he is pretty much unanimously disliked."?-- Yes.

Did any of that come as a surprise to you in May 2005?-- The - what she wrote in her e-mail came as no surprise to me because by that stage I had read the North/Giblin report and was much more acutely aware of some of the problems of which I'd been previously unaware.

As a Director of Medical Services, should you not be aware of these things?-- I would like to be aware.

How do you, in the future performance of your duties, establish a process so that you will know if all the staff universally dislike a director of one of your departments?-- The only way to be relatively confident of getting that is to spend much more time walking floor.

COMMISSIONER: But doctor, can I just take you back to the e-mail from Nurse Dale Erwin of the 17th of June 2004? When she said to you that neither of the SMOs had any respect for Dr Naidoo, she said, "I know that we've been down this track before." Do you remember she said that in that e-mail?-- Yes.

That means that she had said these things to you before?-- If she had said that to me previously, I do not recall her making that comment to me.

But there had before that time been many complaints from her and from other nursing staff?-- There had been complaints about cancellation of cases, there had been complaints about-----

Cancellation of cases by Dr Naidoo?-- Yes.

Yes, yes?-- And the general attitude of Dr Naidoo.

Yes. All right. Thank you. And over what period did you say they were? Quite a number of years?-- Yes.

Yes.

MR ANDREWS: Nurse Erwin Jones had been at Maryborough from May 2002 but went to Hervey Bay sometime later than that; do you recall whether that's correct?-- That's correct, I don't recall when she went to Hervey Bay.

At Maryborough, would Nurse Erwin Jones have encountered - she would have encountered Dr Naidoo working at the Maryborough Hospital, wouldn't she?-- Yes, Dr Naidoo did elective lists at Maryborough Hospital.

Thank you. You say the district's undertaking a process of reconciling fuel docket locations for Dr Naidoo's health service vehicle with his rostered duties. You haven't been able to complete that process, have you?-- No, it's not fully complete. I do actually have a copy of it as of Friday last week with me.

Before I ask you to show it to me, did it - were any conclusions able to be drawn from the research done to-date?-- Yes, I haven't fully correlated all of his leave with where and when he refueled his vehicle, but there are certainly some instances there where, according to the advice from Human Resource and the approved leave, he should have been on duty but the car was filled in locations such as Wednesday at 11.50 a.m. in East Brisbane.

I see. Well, I would appreciate your producing that document?-- That - do you want it now?

Yes?-- It might take a second to find it.

Thank you. While you're looking for it, so as not to waste any time, the fact that the document tends to suggest that Dr Naidoo may have been absent from the Fraser Coast Health District at times when he was on duty, does that accord with things that you'd observed?-- It does not accord with what I'd noticed or found in the past from inquiries.

COMMISSIONER: But it accorded with complaints which had been made to you?-- It accorded with, "Dr Naidoo's difficult to find, we can't find him".

Yes. On how many occasions were there, can you recall, where that was so?-- Don't recall the number of occasions, the majority of the times when somebody did contact me because they were unable to-----

No, no, sorry, again I didn't phrase that properly. How many

occasions were there where his fuel records showed he was in Brisbane when his hospital leave records showed that he should have been on duty at Hervey Bay?-- I honestly can't answer that at this stage, Commissioner.

No?-- I've only briefly scanned the document myself.

All right.

MR ANDREWS: I might accept your invitation to see that afterwards, doctor. You've spoken also of an audit of usage and cancellations for all clinics, theatre sessions and individual orthopaedic patients operations; you foreshadowed that in paragraph 43?-- Yes.

Has it been done?-- It's in the process, it's a huge task and it's all manual collation, there's no computer print-down that you can produce.

So it would be fair to say that the hospital system is such that it's very easy for a person who wants to - a person in the position of Director of Orthopaedics, who wants to take some occasional time off, to do so without being shown up in any records?-- Extremely easy.

At paragraph 47 you quote the AOA report, "Dr Mullen is aware that he does not have the support of either Dr Hanelt or Mr Mullen." You correct that by saying it should have read Dr Hanelt or Mr Allsop; I gather you don't correct the accuracy of it otherwise?-- No, that was simply - it was obvious from what was below it that that's what should have been written in the report.

At least as far as back as 2004, Dr Mullen then didn't have the support of you or Mr Allsop?-- I would disagree with that. I can't speak for Mr Allsop, I can speak for myself.

At paragraph 55 you quote the report again, "It was clear to the investigators that the nursing staff had concerns about the performance of some medical staff and some of the processes in place at the hospitals that they had expressed these concerns to those who were in a position to address the problems but that their complaints usually fell on deaf ears."

The nursing staff would ordinarily be expected to report such complaints to their nurse unit managers?-- Yes, to the nurse unit manager, to the Director of Nursing and the chain of command.

And the Director of Nursing would then report to whom?-- The district manager.

Did you hear about those complaints?-- The complaints that I was made aware of was, there was two e-mails sent immediately before the Commission - sorry, before the review of orthopaedic services occurred plus there were concerns brought up within the surgical management advisory group.

Well, let me deal with those in series. Those two e-mails that were sent just before the investigation, do you mean the e-mails of Dale Erwin and Theresa Winstone?-- Yes.

Which are TMH 21 and 22?-- Yes.

What's the - what was the third source of your information?-- We have monthly surgical management advisory group meetings that looks at the provision of the surgical services within the district which concerns any concerns were brought up in that meeting in relation to whether we will meet targets, whether there's other impediments to providing service, whether that be lack of anaesthetists or lack of orthopods or budgetary problems, the full gamut of problems that can-----

And at those meetings, would you attend?-- Yes.

And would representatives of the nursing staff attend?-- Yeah, they were multidisciplinary meetings, I was the chair, there was members of the nursing staff from the surgical unit, from the theatres, from the specialist clinics and there was medical staff from each of the surgical departments.

And were there complaints expressed at those meetings about the performance of people in the orthopaedics department?-- There was complaints expressed in those about the problems with meeting orthopaedic through-put targets.

Well, that's volume of procedures?-- Yes.

COMMISSIONER: And were there complaints about the doctors with respect to provision through-put?-- Yes, concerns that if we failed to meet the orthopaedic elective surgical targets, then Queensland Health would penalise the district for financially not achieving or reaching those targets.

I thought you were talking about complaints about Dr Naidoo?-- Well, that's complaints about leave that the doctors that decreases the through-put.

So specifically the complaints were complaints about Dr Naidoo's frequent absences?-- Yes, the absence of Dr Naidoo when Dr Mullen was not providing any elective surgical service, the absence of, you know, the impact of that upon our elective through-put.

And were there complaints about Drs Sharma or Krishna discussed at those meetings?-- Not that I'm aware of, not that I can recall, I should say.

All right.

MR ANDREWS: You mentioned the elective surgery targets and the prospect of losing funds being discussed at these meetings. I gather that the elective surgery performed by Drs Krishna and Sharma was a significant matter in attempting to retain whatever elective surgery funding was to be provided to the Fraser Coast Health service district?-- No, the elective

surgery performed by Dr Sharma and Dr Krishna are procedures that carry very low weighted separations, if you understand that term.

Yes, the inquiry's heard that explained?-- So-----

They had to do a lot of procedures?-- A carpal tunnel might count for a half a weighted separation whereas a hip replacement might account for 10, so to get one elective hip replacement performed by one of our consultants was worth 20 carpal tunnel, so that made minimal impact.

And the more complicated the procedure, the more weighted separations would be involved?-- Basically.

So the effect of Drs Krishna and Sharma being permitted to perform more complex surgery unsupervised would have meant that they could earn more weighted separations for the health service district?-- The more complex stuff that Krishna and Sharma were doing was emergency stuff that doesn't get counted towards your targets.

COMMISSIONER: No, no, but supposing, for example, that they did complex surgery in the elective surgery waiting lists, the pressure really was upon them to do more complex operations, the economic pressure on them was-----?-- The economic pressure would probably be more accurately described as if they did trauma work that freed up Dr Naidoo's lists from doing the trauma work so that he could do elective work.

Or if they did it themselves?-- Certainly they could do it if they did it themselves that would also add to the weighted separations.

Thank you.

MR ANDREWS: And whose responsibility is it to maintain the number of weighted separations? Is it the district manager's, Director of Medical Services, Director of Orthopaedics, who's concerned with that issue?-- I think basically everybody's concerned and it's a shared responsibility. That's why it gets discussed at multidisciplinary meetings, that if we're unable to achieve targets in one specialty, then there's a potential to reassign lists to perhaps the general surgeons or the gynae people if they've got patients waiting and time available, so it's a bit of a juggling act at times.

At paragraph 59 you say, "There was disagreement between the local orthopaedic surgeons in relation to allegations relating to the supervision of the senior medical officers?-- Yes.

Should - did you mean to say that you were aware that Dr Mullen thought that the SMOs should be supervised more and that Dr Naidoo felt they were supervised adequately?-- Yes.

Dr Mullen, after an agreement was set out in writing in, I think January 2004?-- 16th of January.

16th of January 2004, Dr Mullen at about that time offered to do on-call work and for free?-- Yeah, he offered to do on-call work and at one stage he said he would do that free of charge.

Why did you not accept - do you agree you didn't accept that offer?-- Yes.

Why?-- There was a couple of aspects in relation to why the offer was not accepted. If I run through them: one was the fact that he had previously stated he would do a one in four on-call but frequently then made himself unavailable. There was no negotiation, it was simply an edict provided from his rooms, usually from his receptionist or his wife to say Dr Mullen will not be available on this day, that day, that day, won't be able to do this weekend, that weekend, so unable to do a one in four commitment made doing a one in two commitment a problem; the second one was just there was a significant financial impact of doing a one in two; another reason that was involved was it was not unconditional, he was only willing to do a one in two if Dr Naidoo also did a one in two on-call.

COMMISSIONER: What was the significant financial impact if he was offering to do it for nothing?-- The significant financial impact is that people who are entitled to be paid industrially for doing something at a later date tend to have a habit of coming back and saying, "Well, I did this, I haven't been paid".

So it was just the level of distrust which existed between you and Dr Mullen which caused you to reject his offer?-- I wouldn't call that distrust, I would call that not being willing to place the district in danger of being hit with a big bill at a later date.

But if he was prepared to make that offer and make it in writing, there'd be no risk of that, would there?-- I'm not - don't have the expertise in law to know whether me agreeing to breach the industrial contract, industrial rulings would stand up in a Court of law or whether it would be-----

No, not about industrial rulings, he's offering to do a service for nothing?-- Yes.

What ruling is that breaching?-- As I said, it's contrary to the award condition, if I agree to forego my award condition and then later make a claim that I should have been paid that was unacceptable to allow me to do that, I honestly don't know what the ruling would be in a case such as that.

It just seems extraordinary to me at the moment and you haven't satisfied me to the contrary that you would have rejected an offer to provide a one in two on-call service for nothing and I just - you haven't really explained it to me in any logical or convincing way, but if you'd like to do so, I'm giving you the opportunity to do so?-- Yes, I'm happy to try to clarify it further. If Dr Mullen was going to do a one in two, he required Dr Naidoo to also do a one in two.

Mmm?-- And if that had been agreed to, yes, that would provide coverage for when they were both within the district.

Yes?-- If either person took leave, then we still would not have a full orthopaedic coverage.

What did you have to lose by it? You didn't have it at the time, what would you have lost by it, accepting a free service one in two?-- If Dr Mullen and Dr Naidoo had both been prepared to do a one in two on-call orthopaedic service, then other than risk of some future financial hassle, there would have been nothing to lose.

Did you ever ask Dr Naidoo whether he would be prepared to do that?-- Dr Naidoo was prepared to do a one in four and one in four only, no more frequent.

All right.

MR ANDREWS: You say at paragraph 60 that, "The cost of Dr Mullen providing an on-call on weeknights instead of an SMO would have amounted to an additional cost, but isn't the point of the consultants or - I beg your pardon, the specialists providing on-call, that there would be an SMO as well for the consultants to supervise; isn't that how it's done?-- Normally if we have a consultant service available, we do not have SMOs within the department.

But that's - isn't that only in the Fraser Coast or anywhere else where there's a shoestring budget that runs a department, that's not; would you agree with that proposition?-- No, the Royal Brisbane does not employ SMOs, they employ Registrars.

Yes, thank you, I appreciate the distinction now. Registrars or SMOs who do not have specialist accreditation, so it's not a specialist who's employed as an SMO but an SMO who doesn't have specialist accreditation would always be supervised in the sense of having a specialist on-call whose duty it is to respond if need be?-- No, there are many SMOs who have absolutely no supervision.

In surgery or in orthopaedics?-- There are in dedicated in surgery and dedicated in orthopaedics are you talking about, I don't quite understand?

The expression "indedicated" I don't understand?-- You have SMOs who work purely in a discipline and then we have general SMOs.

Yes, SMOs working in surgery or SMOs working in orthopaedics, if they are not accredited specialists, I suggest to you they are supposed to be, when on-call, supervised by a specialist?-- I'm unaware of any requirement for that.

Well, it's a suggestion of the Australian Orthopaedic Association, isn't it, that's what the North/Giblin report was substantially about?-- Yes, the North/Giblin report suggests

that any orthopaedic procedure performed by anyone should be supervised by a specialist.

You say that as if you disagree with it?-- I do disagree with it. If you're a medical superintendent at Emerald Hospital and somebody comes in with a dislocated finger, you have no specialist to-----

COMMISSIONER: Oh, we're not talking about emergency surgery now, are we? There's an essential distinction between emergency surgery and elective surgery, isn't there?-- Certainly there's an essential difference.

And in some emergencies something has to be done straight away whether you can get supervision or not?-- Yes, I agree with that.

That's never the case in elective surgery?-- In elective surgery there certainly are procedures performed by non-specialists without supervision other than on the Fraser coast.

That - whether there are or not, that would be negligent, would it not, to allow that to happen?-- I don't consider it's negligent if the person is competent to perform the procedure.

By that do you mean credentialed by an appropriate independent committee to perform that procedure?-- Ideally credentialed but certainly competent.

Well, who else is going to determine, objectively determine their competence?-- The people who have worked with the person who have assessed their competence are in a good position to assess what a person is competent to perform.

In this case you mean Dr Naidoo?-- Yes, in all cases - in orthopaedics, Dr Naidoo.

And your point is that you are prepared to accept whatever Dr Naidoo said they were capable of doing?-- At that stage I saw no reason to doubt it.

MR ANDREWS: At paragraph 65, you quote from the AOA report, "During the interview, Dr Hanelt expressed criticism of each member of the orthopaedic staff at both Hervey Bay and Maryborough Hospital."?-- Yes.

What were - and you don't deny in your statement that you expressed that criticism?-- Yes.

What were the criticisms that you - you ought to have had an opinion about each of those staff as a Director of Medical Services?-- Yes.

You'd agree?-- Yes.

Part of your duty to form opinions about?-- Yes.

What were the criticisms you expressed about Dr Naidoo, if any?-- From memory, I cannot recall exactly what I said at the time but I could certainly tell you what I believe I would have said at that stage.

Thank you, I'd appreciate that?-- Certainly at that stage my concerns with Dr Naidoo was his interpersonal skills or communication skills, whatever you would prefer to - terminology you would prefer to use.

COMMISSIONER: His frequent absences?-- Yes, I believe the - yes, the leave matter was brought up with the AOA, whether that was brought up as a criticism or not, I don't recall.

MR ANDREWS: Well, whether you, if you bring it up, it doesn't have to be a criticism of Dr Naidoo to be a relevant feature of the amount of service delivered by the orthopaedics department?-- I agree, but I was trying to answer your question of what critical-----

I see, and what did you say of Dr Krishna?-- Dr Krishna, the perception among staff was that he worked as much as he had to. That the - and that's the only criticism I can, other than both of the SMOs, there was some concern in relation to language difficulties with patients.

With respect to Dr Sharma?-- Dr Sharma, the only thing I can recall critical in relation to Dr Sharma was in relation to some communication difficulties with patients.

Was that simple language difficulties or personality difficulties?-- I think it was partly language and partly cultural. The language is a - because Dr Sharma was very quietly spoken and does talk with a bit of an accent, certainly with - some patients were unable to understand, and Dr Sharma, Dr Krishna, plus many of our international medical graduates used to - the degree of explanation that patients within the Australian health care system expect.

COMMISSIONER: You mean Australian patients expect more in explanation than they were prepared to provide?-- No, than they were used to providing.

Than they were used to providing?-- Yes.

And that they are were prepared to provide?-- Once they became aware of the additional requirements, certainly they spoke to patients and they were quite happy to review patients, but there's the unfortunate problem that patients - you will explain something to patients, you think you have explained it to them adequately, they walk out with a smile on their face, and then ask the nurse, "Can you please explain what was - what this means?"

Yes.

MR ANDREWS: You say in paragraph 70, "I'm aware of one article in the media in which the two nonspecialist orthopaedic SMOs were referred to as orthopaedic specialists. This error was addressed." How was that error addressed?-- The person that spoke to the media had it pointed out to them that to be classed as a specialist or a consultant you had to be registered as such within Queensland and to refer to them publicly otherwise - in any field otherwise is a contravention of the - whichever Act is in force at that stage.

Who was that person?

COMMISSIONER: Who - sorry.

WITNESS: I believe it was the District Manager.

MR ANDREWS: Who spoke to him?-- I spoke to the District Manager.

Well, you don't just believe it, you know it was the District Manager then?-- Yes.

COMMISSIONER: Who was responsible for putting the article in the newspaper in the first place?-- I don't recall how the newspaper article come about, whether the paper contacted the District Manager because they'd heard about new people starting or whether-----

It wasn't you?-- No.

Right?-- I try to avoid contacting-----

It could not have been anyone other than the District Manager, could it?-- The other possibility was the chairman of the District Health Council, who was very active in the media.

Would he have known?-- Yes, the - all our staff recruitment - this was discussed at our monthly District Health Council meetings and the Chair took particular interest in who he had, who we were getting, and what they were coming for.

MR ANDREWS: But you're in no doubt that it's the District Manager who told members of the media that there were two new orthopaedic specialists?-- I'm as confident as I can be.

When you explained to Mr Allsop that that could actually be a breach of statute to say such things, he responded in a way that showed that he was the one who'd said it to the media?-- I believe - from recollection, I believe that - what occurred is there is the remote possibility that I'd passed it through him to the district chair. Unsure. My memory could be better in some instances.

When you say in the next sentence, "The media is notorious for reporting matters in an incomplete and/or ambiguous manner."-----?-- Yes.

-----there may be many people who agree with you, but you are not trying to suggest that they got it wrong here, are you? You are not trying to suggest that they invented the description "orthopaedic specialists"?-- No.

Because your belief is that Mr Allsop mistakenly used that description?-- Yes.

COMMISSIONER: That's perhaps not mistaken if you look at the certificates of registration, but that's another point.

MR ANDREWS: You say at paragraph 71 that, "Appointments are not made on the basis of the salary level of applicants."?-- Yes.

Well, bearing in mind that you have to consider costs and budgets at your hospital in such detail that you're concerned about whether to engage a specialist to be on call because it might cost $12,000 a year, surely you concede that when you make appointments you think about such things as the salary level of the applicants?-- The process works such that we have positions approved for us to recruit. If we wish to commence a gastroenterology service, we put in a submission, "This is what - the position we need. This is the funding we need." The position, if it was approved, would be approved and we might get approval for three MVO gastroenterologists. We then attempt to recruit to those positions. I don't employ a Junior House Officer in surgery to fill that position

because he's cheaper.

COMMISSIONER: Who's "we"?-- The district.

You are in part responsible for that?-- Yes.

Putting in that request?-- Yes.

Did you ever put in a request for an orthopaedic specialist surgeon?-- Yes. We have - it was approved and we have advertised for the position previously without success.

When was that?-- It was a considerable period ago, several years ago.

Well before the appointments of Dr Krishna and Sharma?-- Yes.

And when you didn't fill it at that time, you didn't make application again?-- No. Once the position's approved, the position sits there on the books, for want of a better word.

I see?-- If I could find one today I would recruit one today.

That's not quite the point that I'm asking you. Having sought one and there were no applicants for the position several years ago, well before the appointment of Drs Krishna and Sharma, did you ever seek to do that again?-- Yes. The position has been readvertised.

When?-- The exact dates I couldn't tell you, but we have advertised at least a couple of times subsequently, plus we have done a - done two mail-outs to every registered orthopaedic surgeon in Australia and in New Zealand in conjunction with St Stephen's Hospital to try and attract staff.

Where do we find those?-- The mail-outs?

The mail-outs and the advertisements?-- The advertisements would be - the HR department at the Maryborough Hospital would be able to provide details. The mail-outs would be available through the CEO of St Stephen's Hospital. Our district and St Stephen's jointly funded the mail-out and St Stephen's organised the mail-out.

But you say Maryborough Hospital. Did you seek one for Hervey Bay?-- This position was a district position. All districts are position-----

I see?-- Sorry, all the positions are district positions.

Right?-- It is just the HR is based at Maryborough Hospital.

We can find those there, can we?-- The advertising details would be found at Maryborough. Stuff in relation to the mail-outs, the CEO at St Stephen's Hospital would be able to provide the dates on which they occurred.

Thank you.

MR ANDREWS: But before engaging Dr Krishna and Dr Sharma, you and Dr Naidoo had discussed the future employment situation in the Fraser Coast Health District and you made a decision to go for two overseas trained SMOs?-- Initially we went for one international medical graduate who we employed to provide a decent level of assistance within the orthopaedic department, and Dr Naidoo was impressed with his clinical ability and he suggested we attempt to recruit a second person, who contacted us. He - obviously the Fijian medical community is reasonably small. We had two Fijian SMOs employed within the district, "He's a chance, I will contact them."

Was the first one of whom you spoke Dr Krishna?-- One was Dr Krishna.

And the second was Dr Sharma?-- No. We had two Fijians. It was a Dr Nair.

You say at paragraph 72 in the last sentence of it, that, "Unfortunately the AOA investigators seem not to grasp this concept". The concept, as I understand it from the paragraph, was the one that sometimes delays in access to specialist treatment in emergency situations can result in a worse outcome than having the service provided by a competent medical practitioner who is not a specialist?-- Yes.

COMMISSIONER: To be fair to the AOA investigators, isn't - wasn't it the case that their report suggested that Drs Sharma and Krishna ought to be supervised by a medical specialist?-- Yes, that's in the report.

That there ought to be better clinical audits?-- Yes.

And you wouldn't disagree with that proposition?-- I agree with that proposition.

That there seemed to be some dysfunctional aspects of the relationships in the orthopaedic department?-- Yes.

You wouldn't disagree with that?-- I won't disagree with that.

That these matters impacted upon the level of care that the orthopaedic department was able to provide?-- Yes.

Do you disagree with that?-- No, I don't, do not disagree with that.

That the long absences that - of specialist supervisors created by Dr Naidoo's leave was unsatisfactory. You don't disagree with that?-- Yes.

MR ANDREWS: At paragraph 73 you say that, "To treat a patient on the Fraser Coast involves the additional cost of the expense of theatre time, the cost of the prosthesis, the cost of post-operative in-patient care and associated allied health

care."?-- Yes.

When transferring a patient, is there any cost?-- The cost that's involved in transferring a patient is the care that they receive within the Emergency Department until they are transferred, and there's the potential costs through the Patient Travel Subsidy Scheme for the family or support person to be in Brisbane with them. But certainly the cost of their in-patient treatment and the cost of their transfer is not - is not borne by the district.

Well, then, when it comes to a recommendation that an orthopaedic department, for instance, be closed, as seems to have been the recommendation by the AOA report, when it came to elective surgery there would have been a financial advantage, are you saying, to the Fraser Coast Health District - except, of course, that, yes, your budget for elective surgery would reduce for the next year probably?-- Yes.

Is that the position?-- Our throughput goes down and the government - well, Queensland Health funds - if you say roughly a thousand dollars a step, then it would go down by 5,000 admissions. They take 500,000 back out of the budget.

You just have to have your services contract and contract if-----?-- Yes. Emergency patients is another matter, because we don't get any - how would you say - funding attached to the patient, so if we transfer an emergency patient some elsewhere we cop none of the cost of that patient and we get no financial penalty for sending the patient.

You say at paragraph 88(iii) that you had conflicting advice from local orthopaedic surgeons as to whether complications from the unsupervised surgery of the SMOs was due to a competence issue or to problems that occur irrespective of competence?-- Yes.

Who were the local orthopaedic surgeons who gave you this conflicting advice?-- Dr Naidoo and Dr Mullen.

Would it be Dr Mullen who was suggesting it had something to do with competence and Dr Naidoo suggesting that it did not?-- Yes.

In respect of how many patients did Dr Dr Mullen reveal his concerns that complications were or may have been due to competence?-- There was two parents that I can recall immediately where he raised concern. One was a patient who's been highlighted in the report in relation to the amputation.

That was from 2000?-- Yes, and there was another patient which was done - I can't remember by Sharma or by Krishna - who sustained a fractured neck of the femur whilst fixing a fractured femur.

And Dr Mullen brought those concerns to your attention promptly after each procedure?-- The arm lady, he brought

that to my attention during the course of her treatment. The fractured neck of femur, I'm unsure whether that was brought to my attention by the doctor concerned, by the theatre staff, whether I went and discussed it with Dr Mullen, or whether Dr Mullen brought the matter to me. I don't remember.

The arm lady of whom you speak, in 2002 Dr Mullen expressed to you concerns not about the SMOs - it's 2000, I beg your pardon - not about the SMOs but about Dr Naidoo's competence in respect of that lady, did he not?-- Well, I wouldn't class it in - in relation to his competence, but whether he'd provided appropriate care.

Appropriate management?-- Yes.

"Management" referring to monitoring her after the procedure?-- In relation to the choice of procedure and the provision of after care.

Back in 2000 was there any protocol at the hospital or protocol prescribed by a Queensland Health policy for reporting adverse incidents such as that one?-- There was. Certainly we had a strict policy in relation to it. I can't remember whether - I know Queensland Health now has a very descriptive policy, but in 2000 I can't remember whether Queensland Health had a policy. But certainly within the district there was - forms were to be filled in by staff in relation to adverse incidents.

What was to happen to the forms after they'd been filled in? Were they retained for the internal consideration of those in the health service district or were they forwarded to Charlotte Street?-- Well, no, certainly for an incident like that at that stage, and still at this stage we're not reporting to Charlotte Street.

And do you know whether a form was filled in in respect of the 2000 incident that Dr Mullen raised with you?-- I don't recall.

Do you recall whether any form was filled in with respect to the fractured neck of femur incident?-- I don't recall.

COMMISSIONER: What did you do about each of those complaints?-- In relation to the lady with the fractured humerus, Dr Mullen when he initially contacted me was in relation to the acute management of that patient. He explained the situation to me and what he believed needed to be - needed to be done with that lady clinically. The lady had been admitted under Dr Naidoo. Dr Naidoo for some reason was unavailable to provide the acute care she needed, so I authorised Dr Mullen to take over care of the patient and provide what needed to be done at the time, and in relation to the greater issue, when Dr Naidoo returned, I spoke to him in relation to two matters. One was the clinical management of that patient and the difference of opinion between him and Dr Mullen, and the second was in relation to appropriate hand over of patients if you are not going to be available.

MR ANDREWS: Were you satisfied with the resolution of that?-- The - in relation to the clinical treatment and the choice of the operation, the explanation provided by Dr Naidoo was very logical, quite convincing, and I'm still in a situation where I'm unsure after discussing it with other people, I still remain unsure as to who was - whose assessment was correct in that situation. And in relation to the hand over of patients, I was given an assurance there would be appropriate hand over of patients in the future.

And the other matter?-- No, that was the other matter, the-----

COMMISSIONER: No, no, the other patient?-- Oh, sorry, the other patient. The other patient was a lady who had a fractured - don't know if it was a lady or man.

You told us what it is. What did you do about it?-- That patient - in relation to that one I spoke to Dr Naidoo, spoke to Dr Mullen and reviewed the literature in relation to it, and the literature, from memory, I think it's about 2 per cent incidents of that complication occurring during that procedure.

What did you do about it?-- At that stage it was an isolated incident which there was evidence to suggest it was a recognised complication, and one of the orthopaedic surgeons - Director of Orthopaedic Surgery stated that it was well recognised complication and it wasn't due to the poor performance of the procedure.

Who said that?-- That was the information provided by the Director of - Dr Naidoo.

Oh, Dr Naidoo said that. Did it occur to you then that this might be an operation which should not have been performed except under close supervision, performed by Dr Krishna except under close supervision?-- It didn't occur to me at that stage, because the Director of Orthopaedics was by far the most senior orthopaedic person within the district and he was of the opinion that the man was competent to perform it and this was a well recognised complication of the procedure.

All right.

MR ANDREWS: Doctor, the fractured neck of femur - are you all right?-- I have just got a cramp, sorry.

COMMISSIONER: Do you want to stand up for a while?-- It's gone. I had my foot tucked too far back.

MR ANDREWS: The fractured neck of femur case performed by Dr Krishna, did you inquire whether it was a case that was listed in Dr Krishna's scope of practice as something he could perform unsupervised?-- No, I did not.

When you recall discussing it with Dr Naidoo, that particular

case, you said that Dr Naidoo referred to this as a complication that occurred in two per cent of cases?-- Yes, there's literature - the literature, I think it was roughly 2 per cent, yeah, less than 10 per cent but certainly not less than 1 per cent.

That is for the neck of the femur to fracture?-- Yes.

We have heard evidence from Dr Krishna, as I recall it, that the neck of the femur was already fractured and it wasn't something that occurred while he was performing the procedure. Do you remember whether that was discussed with you?-- I don't recall.

COMMISSIONER: Is this the first time you have heard that?-- I have heard it from reading the transcripts but prior to that I don't recall hearing it. There was certainly one other case where there was a-----

No, don't tell us about other cases?-- No. Sorry. I don't recall independently hearing this one had a crack that got displaced during the procedure.

Your discussion with Dr Naidoo about that case - sorry, discussion with Dr Naidoo about this case was based on the assumption that it cracked during the procedure?-- Yes, to the best of my recollection that was the discussion.

MR ANDREWS: At paragraph 98 you say, "The view is strongly held personally that the concerns identified in the report that were valid and related to patient safety issues had been addressed prior to the release of the report and the recommendation was not valid at the time of the delivery of the report"-----?-- Yes.

-----"if ever it was." So you are speaking of two things, the concerns on the one hand and the recommendation of the report writers on the other?-- Yes.

Do you mean the view was strongly held personally by you that the concerns identified in the report were valid and related to patient safety issues?-- The concerns raised in the report, some are simply incorrect, some of them are correct.

COMMISSIONER: Before we leave, you are moving on from that paragraph?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Before we leave that paragraph, that's not correct they were addressed, is it, because the concern was expressed in the report that you could not provide an adequate and safe orthopaedic service at Hervey Bay without having four orthopaedic surgeons. That is what was expressed, isn't it?-- In the report they provided the opinion that there should be specialist supervision provided to SMOs if they're performing surgery at all times, and in relation to getting the minimum standards as to we get an accredited registrar post, we would

require fourth orthopaedic surgeons.

I don't know that you have answered my question. Can I ask it again. The view expressed in the report, in effect, was that you could not provide an adequate and safe orthopaedic service at Hervey Bay unless you have four orthopaedic surgeons, at least two permanent staff orthopaedic surgeons and two VMOs, or some other variation of the same. That was - that's the effect of what was said in the report, isn't it?-- My reading of the report is a little different to that. I'm sorry, my reading of the report-----

You don't agree with that?-- No, I don't.

What did it say then about the adequacy and safety of a service without having that number of orthopaedic specialists?-- Don't recall reference within the report to that.

I see. All right.

MR ANDREWS: It's a fact that if you have, for argument's sake, only two orthopaedic specialists, they're to share the on-call one - it's called a one in two, isn't it?-- Yes.

One night out of every two nights they would be on call?-- Yes.

COMMISSIONER: And it's well recognised that that's too much responsibility for patient safety?-- Certainly there's concerns in relation to that, but-----

MR ANDREWS: But did you know that it's recognised or - I beg your pardon. Have you - do you agree that it's recognised that that is too much for patient safety?-- I believe that relates to the AMA safe work hours document.

COMMISSIONER: Do you know that or not?-- It depends on the volume of work that one performs whilst on call. If it's a speciality where you basically spend the nights uninterrupted, the weekends uninterrupted, that's vastly different to if you are an anaesthetist who spends the majority of the night awake when you're on call.

Well, do you think it is a safe and adequate service to provide a system of one-in-two?-- There are risks associated with that. I have trouble with the concept of safe or unsafe. There is always-----

Do you think it is adequate?-- It is less than ideal. Whether that means it is inadequate - to me inadequate is black or white, where it comes down to trying to provide the best and safest - or best - the best service with the least risk within the resources that you have got.

Well, if you haven't got the resources to provide a safe and adequate service, if one leaves aside emergency work for the moment, it is safer and better not to provide it at all, don't you agree?-- Yes.

MR ANDREWS: You recall that the authors said that the on-call component of this hospital is "impossibly heavy with only two registered orthopaedic specialists"?-- Yes.

There is no ambiguity that they mean by that - I beg your pardon, the sentence began "From a professional and personal perspective, the on-call component of this hospital is impossibly heavy". No ambiguity that means it is going to be unsafe?-- Yes, certainly unsustainable.

COMMISSIONER: Well, that means unsafe, doesn't it?

MR ANDREWS: Unsafe for them and for the patients?-- Yes, there is certainly increased risk if it remains at that level and you remain unable to get additional staff.

COMMISSIONER: Therefore it is unsafe, isn't it? Doesn't that follow logically? You seem reluctant to accept something which at the moment to me seems perfectly obvious, but perhaps you could explain to me it is not correct?-- My problem is that I do not see that there is something that is safe, something that is unsafe. There is no service that is entirely safe and there is no service that is entirely unsafe. It is a degree of risk and it is about risk management rather than-----

Well, can I put it this way: it is of such a risk that no reasonable person ought to accept it as an adequate service?-- I would respectfully disagree with that opinion.

All right.

MR ANDREWS: Doctor, your attachment TMH31 I will put on the screen now. It is, I think, the first of your form 1 area of need applications relating to Dr Krishna. May I see the bottom of the page? It was "orthopaedics - provide management of wide range of conditions with minimal supervision"?-- Yes.

Now, "management" would convey to the reader something other than perform elective and trauma surgery, wouldn't it?-- Not to me it wouldn't.

Do you regard that as revealing to a person that the Medical Board - I beg your pardon, Queensland Health and the Medical Board, that you had in mind to engage this person to do elective surgery and trauma surgery unsupervised?-- Yes.

Where it then says "supervision available, Director of Orthopaedics full-time and two by VMOs", is that intended to suggest to the reader that there would be supervision by three specialists?-- I assume that was at the time when Dr Khursandi was participating in the roster.

Yes, but was the intent - I beg your pardon, would a reader deduce from that that there would be three specialists capable of supervising?-- Yes.

At page 49 of your statement, in subparagraph 5 at the top of the page, you speak about the roster from March 2003 to January 2005, and you show the weeknights on call for Drs Sharma and Krishna to be 128 and 117 nights respectively. They'll have been nights unsupervised, won't they?-- Yes.

They were never supervised?-- Yes, essentially unsupervised.

At paragraph 113 you speak about an audit to be performed by an independent reviewer of 82 patients from the orthopaedic service at the Fraser Coast?-- Yes.

Has that audit been commissioned?-- Yes, the audit's been commissioned. The person who is doing the audit has spent considerable time on Fraser Coast reviewing the care of those patients, and when I was last at work that report had not been finalised. It may have by now. I am unsure.

Who is that person?-- Dr Simon Journeaux from the Mater Hospital.

Thank you. Doctor, the - there has been evidence that I would like you to comment upon. The on-call roster was too demanding. I don't think you would argue with that, do you?-- No, I'd agree with that.

Dr-----

COMMISSIONER: Sorry, did you say agree or disagree with that?-- I would agree that the on-call roster in orthopaedics, and basically every discipline within our hospital and the majority of the hospitals, is too demanding.

MR ANDREWS: It was known to you that Drs Sharma and Krishna worked independently?-- Yes.

The hospital needs at least two full-time consultants and three or four VMOs in orthopaedics?-- I will agree with two full-time consultants. Certainly the workload - my personal belief is probably three VMOs. That's when one person's away on leave, full-time - there is always one full-timer there, and if somebody is away there is a one-in-four roster. One in

three is a reasonable roster but once you get to one in two - I have worked one in ones and one in two myself in the past and it is not conducive of good harmony anywhere.

COMMISSIONER: Not conducive to safe medicine either, is it?-- Certainly when you get to the situation where you're tired, it increases the risks to patients.

And if you have a constant one in two, it is likely to reduce a service which is so inadequate and unsafe that no reasonable person should accept it as being something which should continue?-- I will accept that there is - yep, that it definitely burns out the staff, it creates overtired staff, increases the risks to patients. So it is - yeah.

To a point where it is so unsafe as to be unreasonable to allow it to continue?-- In elective stuff I totally agree.

Okay.

MR ANDREWS: Drs Sharma and Krishna would be on duty when there was no specialist in the district available to supervise them?-- Yes.

Dr Naidoo was often unavailable, even in normal office hours, Monday to Friday?-- That was one that I - the word often is a very subjective term so I won't comment on that.

Thank you. It is a well-known fact that over the years Dr Naidoo worked for the district. He often did on call from Brisbane?-- That is a comment I have heard raised but I am unaware of any time when he was in Brisbane when he was on call.

Well-----?-- I am aware of times that he was - or a period when he was in Brisbane when he was supposed to be on duty but I am unaware of him being in Brisbane when he was on call.

Nurse Erwin-Jones on several occasions spoke with you about the lack of support and supervision for Drs Sharma around Krishna?-- I don't accept that.

She raised with you issues relating to Dr Naidoo's supervision and you said you were looking at ways to manage Dr Naidoo?-- That may well have been when the concerns were raised and the AOA were asked to provide a panel to review us - to review the service, I should say.

Nurse Erwin-Jones told you her opinion that Dr Naidoo wasn't suitable to be a director?-- I don't recall that statement.

There was an occasion when Dr Naidoo, for no explicable reason, was unavailable to assist Dr Krishna in January 2005 and turned up at the end of the surgery?-- Yes, I am aware of that case.

Did you explore with him why he didn't attend?-- On that particular occasion somebody contacted me - I cannot remember

if it was Dale Irwin or one other member of the staff - in relation to the availability of Dr Naidoo. I spoke to Dr Naidoo in relation to that patient - or that call to him and was told that Dr Krishna was after an assistant for the operation and that he organised an assistant. The assistant didn't have adequate skills to provide the level of assistance that was required, as in he was a very junior doctor, was unfamiliar with the procedure and he needed somebody who had some familiarity, at which stage Dr Naidoo was again called and he organised for - I think it was one of the surgical principal house officers to assist Dr Krishna with the procedure and he told Dr Krishna if he had any difficulties with the procedure to contact him.

And did you discuss with Dr Krishna his entirely different version of those events?-- I don't recall discussing that with Dr Krishna.

Save for wanting you to give to me that document that you believe is somewhere in your brief case, I have no further questions?-- Would it be acceptable, if I can't locate it, to email to the Commission upon my return home?

Yes, thank you, doctor.

MR PERRY: Could I go first in cross-examination, if that's acceptable to the other parties?

COMMISSIONER: If they are happy with that, then by all means.

MR PERRY: Thank you.

CROSS-EXAMINATION:

MR PERRY: Exhibit 16 to your affidavit is an email from clinical nurse Kris Wyatt. You recall most of the last paragraph being read to you by Mr Andrews?-- Yes.

What wasn't read to you was her last line, when after referring to questions of poor communication, et cetera, she says this: "This may have led to biased and unbalanced opinions being given to the reviewers." Was that a view that you accorded with?-- I certainly had concerns in relation to what may have been given to the reviewers once I read the report.

Thank you. You were also taken to Exhibit 31, which is the area of need position description. Who is that filled out by; Krishna and then signed by you, or filled out by you?-- There is two forms. There is a form 1 and a form 2.

I am sorry-----?-- I would like-----

-----form 1, could that be put back up on the screen, please?

It was Exhibit 31 to Dr Hanelt's affidavit. And the one that I think that was put up was the form 1. That's right?-- Yes, that's my handwriting.

Right. In the other discipline, what you seem to be referring to is a person who can undertake the management of wide range of conditions with, to use your words "minimal supervision". Is that what you were seeking in terms of the SMOs?-- Yes.

And I take it that Naidoo was aware that that is what you were seeking, someone who would be, upon appointment, capable of providing management of a wide range of conditions with minimal supervision?-- Yes.

Thank you. In terms of a matter that the Commissioner raised with you, you said, I think, that there had been complaints over a number of years - and I think, Commissioner, the first date you used was '02, or thereafter, about people being unable to contact Dr Naidoo?-- Yes.

Over those years you investigated those complaints?-- When somebody complained that they were unable to contact Dr Naidoo, I would then personally attempt to contact him.

And I think you said that you were successful on all occasions, the only qualifier being on a couple of occasions over those years you found him on the way to Hervey Bay from Brisbane?-- It probably should be qualified a little further. Occasionally was impossible to personally contact him because he was scrubbing in the operating theatre and you could locate where he was. You could not contact him by phone.

But you could find out that he was on the premises but just scrubbed and ready for operating?-- Yes.

Thank you. And with Dr Kwon, you said, I think, that he initially supervised every operative procedure of Krishna and Sharma. Did that practice change over even the four-month period that he was there?-- In the time that Dr Kwon was there, the supervision went from 100 per cent, to certain procedures being performed by the SMOs without him being in the operating theatre.

Thank you. Thank you, sir.

COMMISSIONER: Thank you.

MR MULLENS: I have no questions, thank you.

COMMISSIONER: Thank you, Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Hanelt, John Allen appearing for the Queensland Nurses' Union. You have been taken to paragraph 55 of your statement this afternoon and you told Mr Andrews that in relation to complaints regarding the orthopaedic surgeons at the hospital, you were aware of two e-mails which you annexed to your statement?-- Yes.

And also matters raised during the surgical advisory group meetings?-- Yes.

Now, it is the fact also that there had been verbal complaints over a period of years, as he had mentioned, from at least 2002 in relation to the orthopaedic surgeons?-- Yes.

In particular, the unavailability of Dr Naidoo on occasions?-- That was one of the concerns was raised.

And also, I would suggest, concerns as to the lack of supervision of Dr Sharma and Dr Krishna?-- Raised by nursing?

Yes, including Nurse Irwin?-- I don't recall the matter of inadequate supervision being raised by the nursing.

In paragraph 55, when you were talking about complaints only being such e-mails on the 17th of June and 18th of June 2004, you were confining that comment to written documentation of complaints?-- Yes, yes.

In your statement, where you referred to those complaints and say "these were submitted after it became known to staff that the review was to take place", are you placing any particular significance on the timing of those complaints or are you merely pointing out the fact?-- It is a fact that they were submitted, then it made me wonder as to why suddenly we would get documentation appearing.

So you were meaning to suggest that these complaints are only being made at that time because the authors may have knowledge of an impending investigation? Is that what you are suggesting?-- I had some concern myself that may be the reason. It is up to other people to interpret what they wish from it.

Well, it is a rather cynical observation on your part, isn't it?-- I find it cynical that there is no documentation, there is an investigation about to occur and suddenly the two unit managers from their areas that would be most able to raise concerns both send off an email.

Well, they had both raised concerns previously, hadn't they?-- There had been concerns raised in relation to the communication skills and the leave matters.

Well, let's look at them. TMH21 you were taken to, from Dale Irwin to yourself, and the district manager. As has been pointed out to you it commences with: "I know we have been down this track before."?-- Yes.

Obvious from the face of the email from Ms Irwin that she'd raised such matters in the past?-- She had raised with me in the past matters with leave, the leave creating problems with meeting elective surgical tasks and interpersonal skills of Dr Naidoo and the hassles that created.

Had she raised in the past matters such as being addressed in this email, that "the orthopaedic surgeons would not work together in a cooperative manner"?-- Don't recall whether she had raised anything in relation to that, but certainly Dr Mullen and Dr Naidoo's poor relationship was no secret within the hospital.

It was no surprise to you that on the 17th of June 2004 you are being told that the difficulties between Dr Naidoo and the SMOs include the fact that they will not cover each other and that patients are left in the ward because of a disagreement as to who should be caring for them?-- There is always the problem with one patient - one doctor caring for a patient who is under another person's care, and nursing staff have a habit of grabbing the closest person rather than trying to locate the doctor who is responsible-----

COMMISSIONER: I don't think you have answered the question.

MR ALLEN: This wasn't the first occasion that the topic had been raised of Drs Naidoo, Sharma and Krishna refusing to attend to a patient claiming that it was the other surgeon's responsibility?-- In relation to orthopaedics I can't say whether that is specifically the case. The matter has certainly been raised previously in relation to various disciplines and the wrong person being asked in relation to a patient.

Look, Ms Irwin says, "If they were my nurses I would performance manage them out of the organisation." That means she'd take those steps available within the Industrial Relations policies of Queensland Health to eventually dismiss them?-- That's what she states.

"But they are not, so I request some assistance on how we are to deal with these matters."?-- Yes.

Did you respond to her in relation to that?-- I don't remember whether I specifically responded to her in relation to that. I don't have a copy of all my emails here, or a recollection of conversations but certainly as the AOA - well, the North Giblin review was about to occur, then that would certainly be looking into the matters that she had brought up.

But she is raising a matter of immediate concern in relation to the behaviour of the orthopaedic surgical staff and its impact upon patient care, is she not?-- Yes.

You decided you would simply wait to see what Giblin and North came up with?-- I expected when they performed their review, which was approximately two weeks after that date, that they would provide a feedback in relation to whether they considered there was a problem there or whether there wasn't a problem there.

So by the end of July 2004, when you haven't received that feedback, did you take other steps to address the concerns raised in this email?-- In relation to the interpersonal communication skills and the coverage of the service, by that stage - I am trying to remember the exact timing of things - Dr Mullen was again performing surgery within the district and - my memory fails me exactly what was done in relation to the interpersonal difficulties.

Well, on the 18th of June 2004, exhibit TMH22, you receive an email from the nurse unit manager of the surgical unit saying that "the ongoing in-fighting between Drs Naidoo, Krishna and Sharma is getting beyond a joke and is affecting patient care." She provides specific examples of difficulties presented by their behaviour: lack of review of injured patients, lack of patient notes being made, and says, "I just wonder whether any of these doctors have the patients' interests at heart. These are just a few of the issues. I would be happy to speak with you further. It is really getting very frustrating and putting a lot of extra stress on me and other staff on the ward. I would like you to consider these issues urgently and please can you let me know if we will be getting an orthopaedic RMO next week." Now, what did you do to address the concerns raised by Ms Winston in that email?-- In relation to the documentation in patient notes, certainly the expectation to adequately document in notes has been passed on to all of the medical staff and not specifically just the two that are involved. The - in relation to the provision of a resident medical officer, I don't recall whether there was one available the following week or whether there was not one available the following week.

Did you respond to the request made to yourself by Ms Winston, that you consider those issues urgently, or take up her offer to speak to her about them further?-- I do not recall whether I spoke to her further in relation to that concern she raised in her email.

See, according to the terms of your statement, it seems you took the attitude that as these e-mails arrived about two weeks prior to the review, it was logical to not investigate the complaints as the review would cover the issues?-- These two e-mails-----

Is that the attitude you took?-- These two e-mails that were received say, "This has been going on for a period." There is an investigation - official investigation about to occur appointed by Queensland Health. For me to go in to perform an investigation immediately prior to an official investigation

would, in my opinion, be classed as tainting that investigation.

So you decided to do nothing then about the complaints in these two e-mails?-- In relation to the interpersonal difficulties and whether there was a safe or whether there was an unsafe service being provided, my belief was that the review that had been commissioned was by far the best mechanism to do something about it.

And as the months passed and passed and passed and you still had not received the results of such a review, did your attitude change?-- Yes.

So what did you do to investigate the complaints in these e-mails?-- There's been meetings with the orthopaedic staff within the district to discuss the ongoing patient management, the necessity to hand over patients appropriately, the necessity to provide care for patients who are not directly under your care if it's necessary at that time.

Did you sit Dr Naidoo down with or without the SMOs and ask him for a response to these allegations-----?-- I don't know.

-----in the e-mails?-- I don't know if I sat down with those allegations and said to Dr Naidoo, "These are the allegations, what are we going to do?"

Did you give Dr Naidoo some type of warning about his behaviour?-- The behaviour, the interpersonal skill difficulties were certainly discussed with Dr Naidoo and Dr Naidoo amongst - was included amongst a group of many staff who had been put through communication skills workshops to try and improve their level of communication within the organisation.

So there was no action taken individually directed towards the orthopaedic surgeons based upon the complaints raised in those e-mails?-- No direct action.

All right. You basically just sat on your hands until you received the Giblin/North report?-- No, I did not sit on my hands. We had the Giblin/North report, we expected when the Giblin/North report was very slow in forthcoming, there was discussion made in relation to what documentation is required and how can we do this - how can we provide the cover for these patients when one person's in theatre and isn't available to provide it and there was agreeance to share patients or share the responsibility for the patients or on the ward share the responsibility of the patients in the clinics. When Dr Kwon was recruited, we increased the level of supervision, we further-----

That was in early this year, wasn't it?-- Yes.

All right, so that's about seven months after you'd received these e-mails?-- Yes, it was a continual process when Dr Kwon wasn't available prior to that obviously, what would involve Dr Kwon could not have been done prior to that but the sorting out of the appropriate documentation and the appropriate ward rounds, the appropriate reviewing patients within the ward was done prior to the arrival of Dr Kwon and certainly with Dr Kwon's arrival, my belief is that he was very diligent in ensuring that occurred to the standard that one would desire.

Seven months earlier you should have investigated the matters concerned and you should have directed Drs Naidoo, Sharma and Krishna to get their act together and to do their job

properly, I suggest?-- I disagree with your suggestion.

One other topic: you've been asked about credentialing and privileging. Now, do I understand your evidence this morning to be to this effect: that as it wasn't viable for the Fraser Coast district by itself to form a credentialing and privileging committee, it was decided to combine with Hervey Bay - excuse me, Bundaberg and that that would allow a bigger group to provide the critical mass to appropriately credential and privilege the medical practitioners?-- Broadly speaking, yes.

And did I understand at the same time you to say that that was going to provide that critical mass without the College input which hadn't been forthcoming?-- Yes, if we were still unable to obtain College representatives, then at least we could have some process that would have some robustness and not be seen to be a bias farcical process.

Yes, so it was an approach that you were taking in your own mind in at least attempting to overcome the difficulty with the lack of College nominees?-- Yes.

And you intended that even without the presence of College nominees, that process could then go and appropriately credential and privilege the surgeons in your hospital?-- It would be less than ideal, but as close as we could comply with Queensland Health policy.

Better than nothing?-- Yes.

And that never occurred, the formal process of credentialing and privileging by way of a committee never occurred, but you didn't simply leave it at that, did you, you took some steps in the absence of that process being a practical one according to policy, to at least determine or to at least determine the privileges of surgeons in your hospital?-- Yes, the process that we had was to once we were able to establish a local committee that would function properly, we combined with Bundaberg Health Service District for the colleges for whom we had managed to get representatives for those disciplines, the credentials and privileging committee met and made recommendations in relation to their privileges. There are disciplines which is notably general surgery and orthopaedics for which at that stage no reps had ever been - no, sorry, not had never been, 10 years ago weren't available at that stage.

I'm not wanting to cut you off, and please continue if you must, but what I'm really asking what did you do then about the orthopaedic surgeons in your hospital when you couldn't get the College nominee?-- The reliance was upon the Director of Orthopaedics to provide an assessment of what they were clinically competent to perform which is part of the credentials process, it's the pre-runner to the formal privileging process.

So you at least satisfied yourself that your Director of Orthopaedics, who was a Fellow of the Australian College

turned his mind to the particular privileges that should be allowed the SMOs under his supervision?-- Yes, certainly Dr Naidoo was asked to assess these guys and determine what they were competent to perform and to provide that documentation which could then go to the privileging committee as part of their credentials.

And in your statement you say the three orthopaedic SMOs on the Fraser Coast have been assessed by local orthopaedic specialists and in the cases of Dr Krishna and Dr Sharma that assessment was by Dr Naidoo?-- Yes.

And that as far as you understood their scope of practice was restricted to that in which Dr Naidoo considered them to be competent?-- Yes.

You were certainly more confident in at least that process having occurred rather than no consideration being given to their privileging simply because a committee couldn't be set up?-- Yes.

And indeed, another step that you took was really to request the review by the Australian Orthopaedic Association?-- Yes.

Because in that regard, you understood that one of the major functions of the review was to basically provide another opinion as to the competencies of the SMOs and what sort of procedures they should undertake?-- Not quite that because the review didn't have time to physically assess the competence but it was rather to provide with a model or a mechanism to do that process the AOA thought was legitimate.

Okay. So what, to seek some advice as to an alternative model to the one set down in the Queensland Health policy perhaps in light of the problems getting College nominees?-- Slightly different to that. Dr Naidoo had done his assessment of their clinical competence, Dr Mullen had a differing opinion. My idea was to get an independent opinion who isn't a local player, who could come in and say, you know, either, "Naidoo's model is fine, run with it", or, "Dr Naidoo's model is inappropriate, this is the model you should use.", this is how to sort out their competence to whether that we send these people down to a hospital they nominate to work for a set period of time or whatever to try and assess their competence, we've done this exactly the same process with another discipline and that college was very cooperative and we organised for the person to go to a hospital in Victoria for three months independent assessment.

Okay. So notwithstanding being able to carry out the Queensland Health policy of credentialing and privileging, according to the letter of that document, you did turn your mind to at least having some type of review of the clinical competencies of the SMOs undertaken by Dr Naidoo?-- Yes.

That was because of you recognising the importance of the aims of the credentialing and privileging policies?-- Yes, certainly it's credentialing and basic concept of risk

minimisation for patients.

As a reasonable Director of Medical Services, you would not have been - you would not have permitted the situation to occur whereby an overseas-trained doctor, not a Fellow of Australian College, was operating upon patients in your hospital without having gone through some type of assessment of their skills by an Australian specialist?-- Other than potentially in an emergency situation, the process was for any of our international medical graduates who came to work there, that a director or consultants within that department had the responsibility for supervising, assessing and releasing the reins as they felt was appropriate.

Okay. But if you had a surgeon who wasn't being supervised, let's say someone in charge of the department, an overseas-trained doctor?-- We haven't had that situation within the district where - we simply have not that had that situation.

Well, I'm asking you to consider that situation; you would not have been comfortable with an overseas-trained doctor undertaking surgery in your hospital unsupervised without having gone through some type of credentialing and privileging by an appropriate committee or peer?-- Yes, our directors, we have several of our directors who are international medical graduates and none of those have taken on a director's position until the College was satisfied that they should either get full specialist recognition or deemed specialist recognition, so they've all gone through the College process prior to appointment.

And in the unusual situation where you might have a director who has not gone through that process, you as a reasonable Director of Medical Services would at least want them to be reviewed by a peer if not by an appropriate committee?-- I honestly don't think that I would be appointing somebody as a director unless they had been through that.

Okay, thank you. Look, TMH 35, can you just explain when that document would have come into existence? It's a Queensland Health Fraser Coast Health Service District Policy and Procedure Manual titled "Medical Credentials and Clinical Privileges"?-- From the evidence given earlier, I think it was some stage in 2003, because I know it was after Dr Keating commenced at Bundaberg Hospital.

All right. Do you have a copy in front of you?-- I've got my entire statement here with me.

Look, do you mind having a look at TMH 35?-- Yes, fine.

And I'll ask you to have a look at the same time at a document which is Exhibit 276. If Mr Groth can assist? Exhibit 276? Do you have your document in front of you?-- Yes, I've got the policy on privileges and credentials.

Okay. Now, it refers to a Fraser Coast Health Service

District Manual but it's the target audience is described as including the Bundaberg Health Service District. The document that you've got - don't worry about that one yet - the document-----

MR McDOUGALL: Could the document be on the screen, Commissioner?

COMMISSIONER: Yes, certainly.

MR ALLEN: Yes, TMH 35. The document attached to your statement, was it arrived at with the collaboration of Dr Keating?-- Yes, the policy bounced via e-mail a couple of times, I can't remember the exact details of who did what and what altered what and the timeframes of it.

The three page document which is TMH 35 has a section right at the end for authorisation?-- Yes.

And that's not filled in?-- Yes.

Are you able to say whether the document attached to your statement is simply a draft or eventually became the policy at Fraser Coast?-- This is what was prepared and lives on my computer, this was then forwarded on to our quality management coordinator who was the lady who then goes through the process of formalising the policies, goes out distribution to the people that's of relevance to see if they've got relevance or feedback prior to policy then going on to the signatory of the policy.

Did it become a policy in the terms that's attached to your statement?-- I cannot say that for certain because I didn't check to see whether there was a signed copy of the document within the district.

Are you aware of any later amendments to the policy as it's shown in the attachment to your statement?-- No, I'm not.

All right. And the other document that's in front of you is Exhibit 276, which apparently is the equivalent Bundaberg Hospital document-----

COMMISSIONER: I suppose we should put that on the screen too.

MR ALLEN: Yes. Perhaps if that should be put on the screen instead. You've had a chance to look at it in front of you, but are you able to say whether you've seen that document before?-- Don't know whether I have or haven't, I quite likely have not seen it in that format.

All right, so there wasn't some document prepared which would be - would relate to both health service districts, there was this collaboration and both Bundaberg and Fraser Coast prepared their own policy documents?-- My understanding or recollection is more that we bounced the document backwards and forwards until we were happy with the content of it and then it was a matter of adapting it to our individual

districts format.

Okay. If we just go back to TMH 35, the only substantive difference that I can discern between the two documents is that there are certain parts of the policy in TMH 35 which don't find their way into Exhibit 276 and there - those parts in your document which are the last paragraph on page 1, "Outcome" and then over the page, the first half of the second page from "Evaluation Method" down to the - immediately before the heading "Criteria", so the whole section on evaluation method doesn't find its way into the Bundaberg document. Do you - can you shed any light as to that-----?-- No.

-----from the collaboration you had with Dr Keating?-- No, I can't recall what was the latest shared draft, you might say, between the two of us and what changes was made in each district. Many districts have different formats in which their policy's laid out, like the content of it and obviously we don't re-invent the wheel, we beg, borrow and steal policies from other districts that are adapted to our own.

I think you've answered it, you can't shed any light as to why the documents might be different?-- No.

Just finally, in relation to your document, just before that heading I referred to, "Criteria", the paragraph reads, "In all instances the committee will also invite input from the relevant department director and specialty college."?-- Yes.

So even according to the terms of the policy that you arrived at for your district, there wasn't any provision requiring more than an invitation of the College to provide input?-- No, and I would expect that the wording of that was because of the major trouble we had getting - so okay, if we stick by one in the colleges, it can't work so we've got to come up with some working document that gives us the leeway to still pursue the process even when the colleges fail to meet their expectations.

So your attitude was as at some time in 2003 that you were going to go ahead with the credentialing and privileging process laid down by Queensland Health whether or not you could actually get a representative of the relevant college on the committee?-- Yes.

Yes. Thank you.

COMMISSIONER: Yes, Dr Diehm, you don't have any-----

MR DIEHM: I do, but I am going afterwards.

COMMISSIONER: Okay. All right. Sorry, Mr Devlin.

CROSS-EXAMINATION:

MR DEVLIN: Doctor, my name is Ralph Devlin. I represent the Medical Board of Queensland. In relation to questions by my learned friend Mr Allen, you spoke briefly about the two pathways for specialists who are international medical graduates working in your hospital?-- Yes.

You spoke of the college process and you spoke of the deemed specialist pathway?-- Yes.

Could you briefly tell us your experience, your own experience, so far as it affects you as Director of Medical Services with an international medical graduate pursuing the pathway through the college process? How does that affect you briefly?-- If they can get deemed specialists registration, it is to the advantage of both the doctor and of the district. If they don't get deemed specialist status, then they are required to fulfil further functions, then that affects the pay rate that they get and whether they have got right of private practice basically.

What information do you get as to whether they have been successful by way of by the pathway?-- When they apply for deemed specialist registration, the district - basically myself, I have to submit reams of documentation and forms to the Australian Medical Council, and eventually when the decision gets made I get a letter from the college or I may get a - from - sorry, the medical council, may be directed directly to me or I may get a copy - I can't recall which it is. The specialist - unconditional specialist recognition, what occurs in that situation is a guy who's just got his piece of paper from the college is very proud to come and present it on my desk.

And ultimately then do you receive advice from the Medical Board that that person has achieved specialist registration?-- When we get the documentation, if the person is already registered as a nonspecialist, then application is made for registration of that person in a specialist category.

You ultimately receive that advice back?-- Yes.

COMMISSIONER: What do you receive?-- Sometimes by phone-----

What do you receive? Do you have the certificate of registration from them, from the Medical Board?-- It's quite variable what we received. Sometimes the morning after the board meeting I'll receive a telephone call from one of the administration officers at the Board. Other times the doctor himself will present me with a letter, I will get a copy of the letter from the Medical Board, or at times the first you know is by checking up on the website, the Medical Board, which any member of the public can look up to see what the registration status is of any doctor.

You can see the certificate of registration, can you?-- You can see what they're registered as. It will say, "Registered as a specialist, general surgeon", or he's Area of Need, Junior House Officer, or whatever category they are registered in.

Well, what consequence they have might be a question of law, which might - I certainly wouldn't be asking you about. But I'm just really trying to get from you what documents you would see. Do you ever see the certificate of registration from the Medical Board?-- We normally don't see the certificate of registration from the Medical Board.

Sometimes you just get a phone call?-- Yes. Occasionally we will get a phone call to say, "This was past at last night's board meeting."

As what?-- Whatever category that's been applied for.

But if it's deemed specialisation, they will say, "As a deemed specialist in X"?-- Yes. I haven't received one in relation to a deemed specialist.

You may have but you didn't recognise it as such?-- I read some of the transcripts as well.

Yes. All right. So, sometimes you get that conversation, sometimes you get a letter; is that right?-- Yes, sometimes it would be - it was a letter to the doctor, "Dear Dr X, you have been registered under category 135 of the medical", blah, blah, blah, "as a Senior Medical Officer in orthopaedics", or "as a junior house officer", or "as a supervised practice as a Principal House Officer", or whatever the Board decided was appropriate.

Yes. All right. Thank you.

MR DEVLIN: But you obviously have had the experience of receiving advice back in respect of some of your department heads, some of your directors, of particular disciplines from the Medical Board that they have achieved specialist registration?

COMMISSIONER: I think what he said, in fact, was that sometimes you will get a letter back saying that he's an SMO orthopaedics. The certificate of registration for Dr Sharma and Dr Krishna, there will be a very real question in law whether that is a letter of registration as a specialist orthopaedics. I don't know whether this witness can say beyond what the words are in the document he gets. You are asking him to reach a conclusion as to what those words mean.

MR DEVLIN: I was asking him for his experience in these cases where his international medical graduate has achieved specialist registration as to what he got back in that case. The witness gave a more general answer about PHO a JHO, so he tended to go across the spectrum.

COMMISSIONER: All right. I don't mind you asking him what the document said. I think the effect of your question is whether it was a registration as a specialist.

MR DEVLIN: I didn't intend that. I intended to ask him what his experience was.

COMMISSIONER: Just ask him the question.

MR DEVLIN: Your experience - I am asking of your experience as to the response you got in the specific cases of those international medical graduates who did, to your knowledge, achieve specialist registration, who sought it and achieved it?-- We have had several of those. The most recent - I have difficulty recalling what the first - certainly the Medical Board provides a letter saying - to the doctor stating that he is registered as a specialist in whatever discipline.

All right. You have had that experience anyway?-- Yes, and if there's any restrictions placed on the international medical graduate, say restricted to the speciality of, whether it be general surgery or anaesthetics or whatever discipline.

Thank you. Commissioner, I wanted to go to a couple of series of documents from the Board's files in relation to Drs Krishna and Sharma. That will take a little while.

COMMISSIONER: Well, I'm in counsel's hands a bit about this. How long would you be, Mr Farr?

MR FARR: About 10 minutes, I would think.

COMMISSIONER: Mr Diehm?

MR DIEHM: Die I will be about 15 minutes, I think, Commissioner.

COMMISSIONER: Yes.

MR McDOUGALL: I submit probably three-quarters of an hour, I might think.

COMMISSIONER: Yes. I wonder if there's a possibility of finishing the other three this afternoon if we sat till 5? I'm in counsel's hands. If someone says they can't manage that, then we can finish now.

MR McDOUGALL: I think it's unlikely the way things are going, Commissioner, that-----

COMMISSIONER: Are we happy-----

MR McDOUGALL: -----you would get to me by 5.

COMMISSIONER: No. Are we happy to sit to 5?

MR DIEHM: I can do that, Commissioner, yes.

MR DEVLIN: I am in your hands, commissioner.

COMMISSIONER: Let's do that.

MR DEVLIN: Sorry?

COMMISSIONER: Let's sit to 5.

MR DEVLIN: Thank you. I will have placed up on the screen the largest of the documents. Yes. I have hard copies for you, Commissioner.

COMMISSIONER: Thank you.

MR DEVLIN: The first of the bundles is from the Board's file in relation to Dr Krishna and this appears on the file, and it's the position description for Senior Medical Officer, Orthopaedics, classification C1-1 to C1-D5, responsible to the Director of Orthopaedics. Down the bottom we see an organisational chart where we see that the position answers to the Director of Orthopaedic Surgery. Are you familiar with that document?-- Yes.

Can we go back to where it's shaded in yellow, please, Mr Operator. firstly, if I can ask you this: how do we know that the position description refers to a specialist or a generalist?

COMMISSIONER: That's a question of law.

MR DEVLIN: Well, it's----

COMMISSIONER: He doesn't know that.

MR DEVLIN: It might be a question of his experience. I will go to other parts of the document.

COMMISSIONER: It is plainly a question of law. You can't ask him that.

MR DEVLIN: I will go to other parts of the document, if I may. On to page 2, there are four dot points under, "Primary

Objectives of the Position", and they each appear to relate - I won't repeat them for the record - but they each appear to relate to the provision in one way or another of a top quality orthopaedic service?-- Yes.

You'd agree with that?-- Yes.

We go to page 4 of the document, under the heading, "Personal Specifications: Education/qualifications.", we see there simply the words, "Registration as a medical practitioner with the Medical Board of Queensland"?-- Yes.

There's no mention there of a specialist registration?-- No.

So when we go back to the front of the document, being the position description for Dr Krishna or it's taken to be, it's on the Board's file for Dr Krishna, and going to the classification, for example, are you able to say from your experience since you have said that some SMOs throughout the State are specialists and some are not; is that-----?-- That's correct.

-----what I understood? That's your experience?-- Yes.

Are we able to say - are you able to say from your experience whether a specialist Senior Medical Officer gets a higher classification with his C1 than a generalist?-- C classification is for nonspecialist Senior Medical Officers. Specialist medical - specialist Senior Medical Officers are on an M0 classification.

Thank you.

COMMISSIONER: That's a public service classification within Queensland Health?-- Pay rate classification.

Pay rate classification?-- Yes.

It's got nothing to do with qualifications, it's a pay rate. It is just you are more likely to be classified on a higher rate if you have a specialist qualification?-- I have always interpreted it differently to that.

All right. Perhaps the interpretation is not a matter for you?-- Yes.

Yes.

MR DEVLIN: On the face - looking at the face of the document, you yourself would say that that indicates a generalist?

COMMISSIONER: No, I can't have you answering those questions - asking those questions.

MR DEVLIN: Well-----

COMMISSIONER: I made it perfectly clear before. The proper construction of this document is a matter of law.

MR DEVLIN: It is a public service document, with respect, Commissioner, and he spoke about pay rates and pay descriptions and what they meant in his experience, with the greatest respect.

COMMISSIONER: I am perfectly-----

MR DEVLIN: It's not a legal document as such.

COMMISSIONER: I am perfectly happy for you to ask questions about what pay rate you would expect that to be, C1 to C5, but that's not what are asking, Mr Devlin. You are asking him to say whether that is a qualification as a specialist in orthopaedics. As I keep repeatedly saying to you, that is a matter of law.

MR DEVLIN: The-----

COMMISSIONER: The question whether Senior Medical Officer, Orthopaedic is a specialist qualification is a matter of law.

MR DEVLIN: I'm asking him for his experience working with these public service documents-----

COMMISSIONER: I understand what you are doing.

MR DEVLIN: -----as to what designation a specialist Senior Medical Officer is and as to what designation in his experience a generalist Senior Medical Officer is.

COMMISSIONER: I'm telling you over and over again that it's not a question of experience. His experience is utterly irrelevant to any question I may decide about that. It is a matter of law. But I'm not stopping you. Now, please do not try to ask that question again in some different way.

MR DEVLIN: I shall go to the next document, if I may. The next document in the bundle has a position description on it. It should be a handwritten one dated 22 May. Is that in your handwriting?-- I believe so.

If we go to the second page of that document, firstly, does that relate to the first period of Dr Krishna's service, 18 July '02 to 18 July '03?-- Yes.

That's your signature?-- Yes.

If we go back to the first page then, you have seen fit to write, "SMO Orthopaedics"?-- Yes.

If it was a position that you understood to be a specialist position, would you have written anything different to that as a matter of practice?-- It would have been filled in differently because the "Specialist Practice" under the, "Type of Practice", "Specialist Practice" would have been circled as well, and then "Hospital". Then under, "Speciality", it would say "Orthopaedics".

Where's the position in that - for speciality - yes, I see.

COMMISSIONER: On the front page.

MR DEVLIN: Down at the bottom of the box?-- Yes.

So on this occasion, though you haven't circled, "General Practice"-----?-- No.

Ordinarily one would circle "General Practice?-- No, I don't - the service I am involved in is a hospital not a general practice .

I see what you mean. Sorry, I am with you. So you have circled "Hospital", and if you understood the person taking the job had specialist qualifications, you would have made further entries on the form?-- Yes, if it had have been a - somebody who had specialist - the only type will fit into that - who has deemed specialist qualifications, because if they were fully qualified then we wouldn't be filling in an Area of Need form at all, they would just get registered, so it would only apply to a deemed specialist in which case I would fill out - would circle - wouldn't - in the first column I would circle, "Specialist Practice", not "Hospital", and then immediately to the right of the, "Specialist Practice" I would circle, "Hospital", signifying it's a hospital rather than private practice. then I would write in whatever speciality was involved. I have never done one in that category so it's a little confusing with - but I believe you also need to circle, "Private Practice" because full-time specialists have a right of private practice.

COMMISSIONER: Doctor, as I understand the time sequence, and please correct me if I'm wrong, this document was filled out before he was registered by the Medical Board; is that not correct?-- He was registered at Toowoomba as the Area of Need registrant at the time that we filled that and we applied to have his registration changed from registered to practice at Toowoomba Health Service to registered to practice at Fraser Coast.

I see. In the same way-----?-- I think in Toowoomba he was registered as a resident medical - because in those days the Medical Board tended to not delineate whether a Junior House Officer, Senior House Officer, Principal House Officer. They had Resident Medical Officers and Senior Medical Officer.

But you - was he - you don't know the form of his registration was at Toowoomba, or do you?-- I believe - I haven't got his CV with me, but I believe he was a PHO at that stage.

Did it say "PHO" or did it say "PHO Orthopaedics"? Do you know what it said in that respect?-- No, I don't, sorry.

MR DEVLIN: I can tender the Board's file in that respect.

COMMISSIONER: I don't see any of this as relevant to anything

that I have to decide, Mr Devlin. As long as you don't ask questions of law, I don't mind you asking the questions. But I can't see it's relevant.

MR DEVLIN: If we go to the next document, please, the certificate of registration, 18th of July 2002. Go further down the document. 18th of July 2002 to 18th of July 2003. I am just interested in the description, "Special purpose activity to practice at Fraser Coast Health Service District or any other public hospital authorised through the Medical Superintendent on a temporary basis." Is that consistent or inconsistent with the job description that we have looked at before for Senior Medical Officer?-- That categories of special purpose activity basically says he can do anything, anywhere, as long as I say so. He can do a heart transplant, according to that document, basically.

Thank you. Now, if we go to the next document, which is dated 24th of April, and going down to, "Description", again, "Senior Medical Officer, orthopaedics" - perhaps you should see the second page to see that you were the author of the document. 17th of April 2003. So you were the author of it?-- Yes.

And again on the first page you have used the description which is the same as the job description for the position?-- Yes.

Thank you. Now, if we go over to the next document, which is the certificate, resulting from that application the words are "to practise as a senior medical officer in orthopaedics at Fraser Coast Health Service district or any other public hospital authorised by the Medical Superintendent", et cetera. Is that description consistent or inconsistent with the position that you thought you were filling?-- Well, that's entirely consistent.

Thank you. Over to the next page, the form 1, I think you have seen this before. Your signature is on the bottom, 11th of May '04. So these forms have changed over time, have they?-- Yes, there have been multiple changes to all of the various forms.

Thank you. If we go up again to the top, "senior medical officer (ortho)", is that consistent or inconsistent with the position description that we looked at at the start?-- That is consistent with the position description.

Thank you. Go to the next document, which is the certificate. The description this time is "to fill an Area of Need at Hervey Bay Hospital and Maryborough Hospital, or any other public hospital authorised by the Medical Superintendent on a temporary basis". Is that consistent or inconsistent with the job description that we looked at earlier?-- Consistent, with considerable more latitude.

Thank you. Then go to the last document then. Again you were the author of it. If we look at the second page, you are the author of it on the 30th of November 2004?-- Yes.

If we go back to the front of the document, the position description, is that consistent or inconsistent with the position description we examined earlier?-- Consistent.

If we go to the resultant certificate, "to fill an Area of Need as a senior medical officer in orthopaedics at Fraser Coast Health Service district", et cetera. Is that consistent or inconsistent?-- Consistent.

Do I take it from your earlier answer, in fact that's more specific than one of the other registration certificates you have seen?-- Yes, there was two other documents produced there that didn't specify orthopaedics.

Thank you. Can I take you now to a second bundle, a smaller bundle in relation to Dr Sharma?

COMMISSIONER: Just before you depart from that, someone might explain to me at some stage what the difference is between these certificates of registration and those which were tendered this morning. 438.

MR DEVLIN: I believe one of them is among the Board's files.

COMMISSIONER: Is it.

MR DEVLIN: But there are others that have been issued over time.

COMMISSIONER: Could I see Exhibit 438? You go ahead and I will have a look at it while you go on.

MR DEVLIN: Thank you. In relation to Dr Sharma, is it your understanding that Dr Sharma's position description was of the same type as the one we've looked at for Dr Krishna?-- Yes.

If we look at the first in the bundle we see Dr Sharma's name, we see the description-----

COMMISSIONER: Well, if they are in the same form, do we need to go through them again? I don't mind you tendering them for what they are worth.

MR DEVLIN: Can we go to the certificate of registration?

COMMISSIONER: Yes, thank you, they are the same document.

MR DEVLIN: Thank you. So that citation on that registration certificate is of quite a general nature?-- Very general and mentions Medical Superintendent of Maryborough.

COMMISSIONER: Look, what these things say speak for themselves. Why are you asking him what they say there?

MR DEVLIN: I will tender them.

COMMISSIONER: You can put the documents in if you like.

MR DEVLIN: I will tender them, Commissioner, if I may.

COMMISSIONER: Thank you. Do you want to tender them separately or both of them as one exhibit?

MR DEVLIN: Perhaps it might be easier to tender them separately.

COMMISSIONER: Very well. The documents with respects to Dr Krishna are exhibit 446.

ADMITTED AND MARKED "EXHIBIT 446"

COMMISSIONER: And the documents with respect to Dr Sharma Exhibit 447.

ADMITTED AND MARKED "EXHIBIT 447"

MR DEVLIN: I indicate I hope I have a document tomorrow which will specifically address these matters.

COMMISSIONER: I don't know what you mean by that but we will make it tomorrow.

MR DEVLIN: Thank you, doctor.

COMMISSIONER: Yes, Mr Diehm?

CROSS-EXAMINATION:

MR DIEHM: Thank you, Commissioner. Dr Hanelt, my name is Diehm and I act for Dr Keating. I just want to ask you a few questions about credentialing and privileging. With respect to the history of the joint committee between Bundaberg and Fraser Coast, can I suggest to you that the process towards establishing that joint committee was one that was underway prior to the arrival of Dr Keating at the Bundaberg Hospital?-- I am uncertain. May have been initiated by his predecessor, I don't know.

Can I suggest to you there had been work done between Fraser Coast and Bundaberg in the time that Dr Nydam was the Acting Director of Medical Services. Does that ring any bells?-- Does not ring a bell.

Thank you. Well, I suggest to you that the history is that the finalisation of the policy and the ultimate establishment of the joint committee process was one that was completed by yourself in consultation with Dr Keating?-- I am confident that that was concluded between myself and Dr Keating. Whether it was initiated prior to Dr Keating's commencement at Bundaberg, I honestly don't know.

Can I suggest to you that the time of the conclusion of that process involving Dr Keating was in around the middle of 2003?-- That could well be true.

And is it at that stage you yourself undertook, on behalf of the joint committee or the joint endeavour, to seek out nominations from the respective colleges?-- Yes.

Now, you were unsuccessful in obtaining any of those nominations by the end of 2003, early 2004, is that right?-- Couldn't recall the date. We did get nominees for a couple of colleges. What dates, I haven't got any documentation with me and my independent memory can't tell me that.

Did you end up delegating your involvement - direct involvement in the organisation of these things to a Deputy Director of Medical Services?-- Yes, in January 2004 there was a Deputy Director of Medical Services for the Fraser Coast District employed and the foot work in relation to the

credentialing process was part of his responsibility.

And was that a Dr Gopalan - is that his name?-- Dr Gopalan.

Thank you. To your knowledge did Dr Gopalan pursue college nominations?-- I believe he did.

And would you agree with my suggestion that he continued the pursuit of those nominations at least through until late 2004, perhaps into 2005?-- I would agree, and it is even beyond that date that we are still pursuing college nominees.

Do I take it from your answer that to this date Fraser Coast has not yet had a credentialing and privileges committee meet with the aid of college nominations in the area of surgery?-- That's correct.

You have spoken in your evidence about a plan to abandon the pursuit of college nominations if they would not come forward. Has that plan not come to fruition yet?-- I would not call it abandoned. I'd call it the do the next best alternative whilst still pursuing. We have very recently received - not from the Australian branch of the College of Surgeons, but by contacting the Queensland chair of the College of Surgeons, a nominee and since the - I wrote to the AOA in addition on the third letter requesting a nominee. I pointed out that there was a matter in which the Commission was taking considerable interest and I got three nominees.

Thank you. But certainly by early 2005 you hadn't taken the step of discontinuing, even temporarily, the pursuit of college nominations for the credentialing and privileging committee?-- I cannot state exactly what Dr Gopalan's done in relation to it but my philosophy and what I have worked towards has always been to try to get college representatives to make the process as robust as is possible.

The only credentialing and privileging committee meetings there had been, I would suggest to you, since the formation of this joint adventure, were in areas other than in surgery and took place in the latter part of 2004. Does that agree with your recollection of how things panned out?-- Yes.

Now, in answer to some questions from Mr Allen from the Nurses' Union you explained about or elaborated on what you did with respect to the SMOs in orthopaedics and how you sought out the views of the Director of Orthopaedics as to what was the appropriate degree of privileges for them to be given, pending their undertaking a formal credentialing and privileging process through the committee. You will recall that?-- Yes.

Now, I take it that the result of your consultation - or the outcome following your consultation with Dr Naidoo was that you arranged for the granting of interim privileges to those doctors based on that advice?-- The doctors that are employed within the Fraser Coast, who took primary responsibility for patient management, all had interim privileges granted. The

exact timing in that, in relation to Dr Naidoo's production of documentation in relation to clinical competencies, the timeline, I'm unsure.

But the process was one whereby you obtained advice and then granted interim privileges?-- Or recommended to the district manager they be granted interim privileges.

That is because the doctors either have to have privileges granted by a committee, or if you are awaiting that process, you grant them interim privileges?-- Yes.

Now, does that mean that Dr Naidoo, as the Director of Orthopaedics, was also given clinical privileges?-- Yes.

Who provided the advice to you, if anyone, before he was granted interim privileges?-- In relation to the people who had full Australian specialist registration who remained fellows of their college and remained specialist practitioners registered by the Medical Board who wished to practise within the defined scope of their college's, you know, scope of service, I did not consider it necessary to go to independent third parties who would presumably know less than their college and the medical registration board.

We have heard from Dr Jayasekera, a general surgeon. He has given evidence before this Commission. Do you recall Dr Jayasekera?-- Yes, I remember Dr Lucky.

Yes, that's the name he is apparently known by. We understand that he worked at Bundaberg Hospital for a time and then ended up at Hervey Bay for a time after that?-- Yes.

And with respect to his clinical privileges at Fraser Coast, he said that when he arrived at Fraser Coast or at Hervey Bay, he was told that the privileging that he had been given at Bundaberg Hospital some time before would be relied upon as the basis for privileges for him at Hervey Bay. Does that fit with your recollection, the process?-- That is quite likely the process. It is normal to take into account the clinical privileges that have been provided in other institutions within Queensland.

However, the policy - the Queensland Health policy that we have had in evidence here that underlies the local policies that you have also referred to in your evidence, provides, does it not, that privileges are to be granted for the doctor at the hospital?-- Yes.

So that if a doctor arrives at a new hospital, having worked elsewhere, their privileges need to be assessed at the new hospital?-- Yes.

Now, absent having that formal privileges committee in place, should we take it that what you did with Dr Jayasekera was use the privileges that were previously been granted to him some time before as an informer to you as to what would be appropriate to give him by way of interim privileges in the meantime?-- I don't remember the exact details at that time, but certainly if a doctor had moved from just, say, Royal Brisbane Hospital to Fraser Coast, then they would quite likely have different privileges because of the different facilities we have there, somebody who moves from a place like Bundaberg which has basically got identical facilities and identical support services, then if that's appropriate for somebody at Bundaberg, that is also going to be appropriate for somebody at Fraser Coast.

Doctor, what I'm going to suggest to you that the thought process in your mind in granting the interim privileges to this range of doctors whilst you were waiting for there to be formed a committee in place and it might be suggested and I do suggest to you that the thought process that you engaged in was to look for some sort of indicator to provide you with a basis for being satisfied that you should recommend interim privileges to the district manager?-- Yes, I agree with that one look at the credentials which comes in various forms to make an informed decision.

Now, in that respect, when it comes to the SMOs, the overseas-trained SMOs who were working under the supervision of the Director of Orthopaedics, you were able to go to the Director of Orthopaedics and obtain his advice as to what was appropriate for those doctors?-- Yes.

In the case of doctors such as the Director of Orthopaedics but not limited to him, being a member of an Australian College, was a sufficient informer for you as to what was - as to whether it was appropriate to grant them interim privileges?-- If he was brand new on staff, that would apply.

That the doctor was a doctor who'd come from a similar health service and had privileges granted there, that was another basis upon which you might inform yourself-----?-- Yes.

-----that it was appropriate to grant interim privileges?-- Yes.

Now, you didn't have the situation, but in the hypothetical sense, if you understood that the general - that you had a general surgeon who was the Director of General Surgery - Director of Surgery at your hospital, who you understood to have been trained as a surgeon in America and to have worked in the United States for many years as a surgeon, that would also be a basis from which you would have reasonably satisfied yourself that it was appropriate to grant interim privileges pending the committee's review?-- Having not been in that situation, that does call for speculation. If we-----

COMMISSIONER: You don't have to speculate if you don't want to?-- Yes, if it wasn't a director's position, because I

would have problems with somebody being employed as a director who doesn't have appropriate deemed or general specialist qualifications, but if you employed somebody who was an American trained specialist into a particular discipline as a specialist, then I could certainly see that initially you would say this guy's trained in America, American contemporary standard to us, if he's got a clean slate there, then there's no reason why he shouldn't be able to practice within our shop.

Thank you. And that might be a different situation depending on where overseas he's come from, based on the reputation of that country for the quality of the doctors it produces?-- Definitely.

But America, on your understanding, produces specialists of a high standard?-- Yes, we've had several American trained specialists work with us on a temporary basis and I've been satisfied with the services of almost every one of them.

Thank you. So leaving aside the complication of the Director's position, are you saying that to your way of thinking looking at it from the point of view of granting interim privileges whilst you're waiting for the committee to get up and running, an American trained specialist with years of experience practicing in America to your knowledge unblemished is as good as being a member of a College, specialist College here in Australia?-- If the man comes, he gets a certificate of good standard, registered by the Medical Board, has good referee reports, then I would expect that he would - I'd recommend granting of clinical privileges within the defined specialty in which he's evidenced he's trained.

Thank you. Doctor, one final thing: are you able to say why it was that by, say, late 2004 when there was still no nomination from the College of Surgeons for a participant on the committee, the privileges committee, why you had not taken the decision to by-pass the College with respect to the committee?-- I would say the probable reason for that is, was simply a matter of hadn't got around to doing it with the 1001 jobs to get done, most of which you never get time to do as good as you would like to do, that's one of the ones that would fall into that category.

Doctor, do I take it from your answer that the obligations of the Director of Medical Services at a hospital, or at a district the level of Fraser Coast were so onerous that you did not have time to devote your attention to all of those sorts of details?-- Yes.

Thank you. Thank you, Commissioner, thank you, doctor.

COMMISSIONER: Thank you. We'll now adjourn.

THE COMMISSION ADJOURNED AT 5.01 P.M. TILL 10.00 A.M. THE FOLLOWING DAY